A Portfolio of Academic, Therapeutic Practice
And Research Work

Including an investigation into psychotherapeutic constructions of eating
disorders and a further investigation into the ‘dialogic unconscious’

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Statement of Anonymity:
The confidentiality of clients and participants has been protected throughout this Portfolio. Whenever client or participant material is referred to, names have been replaced with pseudonyms and any identifying information has been changed or omitted to preserve the anonymity of those involved.

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Introduction to the Portfolio

The discipline of counselling psychology has been described as fragmentary and disparate (Strawbridge and Woolfe, 1996), encompassing a number of theoretical and methodological approaches and a range of epistemological stances. This reflects a dynamic and evolving profession that questions the nature and place of psychology and of psychotherapeutic practice within its many contexts (Woolfe, 1996). Additionally, in its concern to value the therapeutic relationship as a meaningful transactional encounter, there has been a focus upon the therapists' role in the delivery of psychotherapeutic services. The diversity of theoretical stances possible within counselling psychology is reflected within this portfolio. The Academic, Therapeutic and Research Dossiers all demonstrate a familiarity with a range of theoretical and methodological approaches, together with the ability to draw upon and make relevant those approaches in clinical practice. However, the dominant epistemological stance taken throughout this portfolio is social constructionist. This is particularly apparent in the Research Dossier, which adopts that perspective in one form or another in all of the three works in this section. My interest in social constructionism developed from the women's studies courses I took as part of my undergraduate degree, where much of the focus was upon deconstructing the gender assumptions that underpin modernist thinking.

Immediately prior to taking that degree I had been the editor of a trade journal for those working with people who required residential and nursing care, primarily the elderly. Concurrent with my undergraduate studies I arranged conferences for residential care managers. Many of those speaking at the conferences and writing for the journal were psychologists whose interests were directed towards the improvement of the social conditions of people living in residential care. For instance, they tried to persuade care managers to provide residents with a key to their own rooms, something they had been reluctant to do, fearing that those in their care would lock themselves in or be unable to remember where they had put them. It seemed to me that these psychologists were working to encourage carers to break away from the traditionally restrictive codes regulating care homes and to find and use greater humanity in their work. I could see that, in the main, their interventions benefited both carers and
residents and it was deeply satisfying for me to be a part of that process. Having had such an amenable taste of psychology, I wanted more and thus, although having acquired a university degree several years previously, I embarked on my studies.

Throughout some of the time I worked on the trade journal, I also attended psychoanalytic psychotherapy. This was a wholly positive experience that helped me to flourish and develop my potential in many areas. It too gave me an interest in pursing an area of psychology that would facilitate similar processes in other people. I was attracted to counselling psychology because it looks beyond the medical model of psychotherapeutic practice in its consideration of the client/therapist relationship and it endorses a humanistic value system of empathic, positive regard towards its clients. I have endeavoured to uphold those principles throughout my training and they are evident in the fabric of the work presented here and in particular in the Therapeutic Practice Dossier.

The cultural and historical environment in which I am embedded has influenced the values that I bring to my practice and to my research and their contribution to the approach taken in this body of work is undoubtedly significant. That I am a middle class, white woman who grew up in mid-Canada and who has experienced several previous careers will have an impact on the way that I pursue my research interests, perceive my clients and conduct myself within the institutional contexts that I now work. Before immigrating to the United Kingdom, I completed a media studies degree and subsequently worked as a journalist and film producer for a major Canadian television network. The understandings and perspectives that I now hold have been considerably influenced by this background and the experiences that are attached to it, just as my work on the trade journal has influenced the view that I have of elderly people. Between completing my undergraduate psychology degree and undertaking this doctoral training I spent a year working with women who struggled with distressed eating practices. That experience too is apparent within this portfolio and again, this is particularly apparent within the Research Dossier.

The portfolio begins with a selection of four essays, contained within the Academic Dossier. The first two essays illustrate a grasp of psychodynamic and cognitive
behavioural (CBT) principles respectively and to some extent they relate theoretical issues to matters of clinical practice. Additionally, the CBT paper considers macro level concerns about the professional identities of counselling psychologists and the emphasis we have placed upon the importance of the therapeutic relationship in our development as a specialist discipline. Both CBT and psychodynamic approaches adopt a realist epistemological stance and, although I am critical of such methodologies later in the portfolio, I have included these works as a means of demonstrating my knowledge of their foundational principles and the contribution of their theoretical perspectives to contemporary practice. The third paper in this collection presents a discussion of Billig’s (1997) notion of the dialogic unconscious and it introduces my interpretation of how this concept might be made therapeutically relevant. The final piece of work in this section takes a critical stance on Freudian interpretations of ‘reality’ and the way in which the therapeutic endeavour can pathologise distressed individuals.

The Therapeutic Practice Dossier introduces the context of my clinical work and describes other therapeutic work undertaken on placements. The final clinical paper provides an account of the integration of theory and practice into my therapeutic practice with respect to my experience of being placed within a number of NHS contexts that required adherence to a particular model. It discusses my strengths and limitations as a therapist and the use I have made of supervision and it traces the history of my personal and professional development as a counselling psychologist.

The Research Dossier begins with a review of literature concerning eating disorders spanning from the Medieval saints through to the present day and it is followed by a discourse analytic study of therapist and interviewer constructions of Anorexia Nervosa (AN). Although these two pieces of work were not written in consecutive years of study, their subject matter is linked and they are therefore most appropriately and logically placed together. The final research paper is again a discourse analytic study also concerned with therapeutic endeavours, however it is concerned with the study of what has been termed by Billig (1997) the ‘dialogic unconscious’. All three of these papers adopt a social constructionist approach and therefore an epistemological coherence is maintained throughout this research profile. Although
the final two papers utilise a discourse analytic methodology for the analysis of data, there are considerable distinctions between the two approaches. In the study related to AN, the preliminary stages of analysis, especially selection procedures, were guided by Potter and Wetherell (1987), whereas later readings were grounded in Parker’s (1999) critical approach to the analysis of discourse. This differs fundamentally from any approach that is concerned with the dialogic unconscious because Billig’s (1997) concept requires modification to the principles of discursive psychology upon which traditional discourse analytic methodologies are founded.

All three projects in this Dossier consider the implications of their conclusions for theory and psychotherapeutic treatment. The literature review examines the social and historical foundations of eating disorders based on a selection of historical literature concerning constructions of self-starvation from the Middle Ages through to the first recorded diagnosis of AN in the 18th century. ‘Feminist’ psychoanalytic approaches to eating disorders are examined and criticised for their reliance on concepts and practices that oppress and subjugate women. A social constructionist, narrative approach to therapy is considered to be significantly less problematic for feminist therapeutic practitioners working with women with eating disorders.

In the paper Size Matters: Psychotherapeutic Discourses of Anorexia Nervosa, the focus is upon therapists' accounts of AN and their own roles in its treatment. The research also examined how accounts of AN were jointly produced in therapist and interviewer conversational interactions. Eight therapists were interviewed using a semi-structured format and transcriptions of these conversations were discourse analysed. Three extracts from three different therapists were used in the final analysis. In extract 1, the therapist drew upon a psychoanalytic discourse and constructed her client’s mother as being overly enmeshed and emotionally reliant upon her anorexic daughter. Extract 2 concerned the contrasting of a successful with an unsuccessful therapy by the therapist, who constructed one of her client’s as being overly enmeshed with her. Finally, in Extract 3 a male client who was unable to utilise therapy was compared with a female client who successfully recovers from her anorexia.
The Dossier concludes with the paper, *How Rude Can You Get, The Dialogic Unconscious in Therapy*, which links the seemingly oppositional domains of discursive psychology and psychoanalytic theory. It employs the Freudian notion of repression to explain why certain utterances are privileged over others and it suggests that discursive acts have repressive as well as expressive functions. According to Billig (1997, 1999) the temptation to be rude is so routinely repressed that an unconscious rhetorical skill is acquired in order to facilitate politeness (also known as ‘everyday morality’, Garfinkel, 1967) within everyday conversations. Six therapy sessions - three from each of two clients - were discourse analysed in order to examine the utility of the concept of the dialogic unconscious. These sessions were examined for instances of client’s talk about everyday morality and for evidence of discursive repressions. The research identified repression as a feature of psychotherapeutic talk and found that it was implicated in client’s conceptualisations of their perceived psychological difficulties. It was concluded that the dialogic unconscious could be observed in therapist/client interactions. This study therefore establishes a research basis for the views that I have expressed in the essay *The Dialogic Unconscious: The Missing Link or a Contradiction in Terms?*, contained within the Academic Dossier.

In addition to providing fresh insights into both historical and contemporary social constructions of eating disorders and in particular Anorexia Nervosa, this portfolio provides a useful platform for the adaptation of the discourse analytic practices of discursive psychology. It also affords psychodynamic practitioners with a helpful means of incorporating a social constructionist ideology and perspective into their clinical endeavours.
References


Academic Dossier

This dossier contains a selection of four academic papers submitted over the three years of my psychotherapeutic training. The first three papers are diverse in their approach and discuss a range of theoretical models of therapy including psychodynamic, cognitive behavioural and the ‘dialogic unconscious’ respectively. The ‘dialogic unconscious’ is a notion that links psychodynamic theory with social constructionism and the submitted paper includes a personal account of how I incorporate the concept into my therapeutic practice. The final essay contained within this dossier addresses issues related to the ‘Context of Counselling Psychology’ and in particular it concerns Freud’s conceptualisation of ‘fantasy’ and ‘reality’ and how this has affected contemporary psychotherapeutic practices.
Countertransference, the Essence of the Therapeutic Relationship

"The patient's hook catches its fish in the analyst's unconscious and reels it in".
Searles, 1958: 247

The analytic relationship is commonly acknowledged to involve two primary and inter-related processes: those related to transference and those related to countertransference. The latter will be the central concern of this paper. The above quote is an apt reference to the phenomena of countertransference made by Searles (1958) and later noted by Young (2000), who believes that the fundamental role of countertransference in the therapeutic relationship is insufficiently recognised by many psychoanalytic practitioners. Moreover, Young believes that countertransference not only provides the basis of knowledge for what occurs between patient and therapist but is also "the basic process in all human communication and knowing" (1990: 12). To begin to understand the term countertransference it may be helpful to briefly discuss the concept of transference and to identify its role in the therapeutic encounter and ultimately in the psychological healing process. The crucial relationship between transference, as experienced by the patient and countertransference, as experienced by the therapist, will then be explored and discussed with particular reference to the clinical practice of this writer.

In 1910 Freud first characterised the transference of emotions and experiences founded in early childhood occurrences and fantasies and re-experienced within the analytic relationship as transference neurosis, or as a "compulsion to repeat" (Freud, 1920: 229). He believed that transference could take either of two forms - it could cause the person under analysis to experience the analyst in precisely the same way as he had experienced an important figure from the past; or, he could replay the analytic experience in such a way that a wished for relationship with an important figure from the past was enacted. Either way, Freud proposed that the re-enactment compulsion was undertaken not as a conscious process but as an unconscious attempt to overcome the relational disturbances and imbalances founded in early childhood. The psychoanalytic method that Freud evolved is therefore primarily based upon his
theory of the mind and also on his understanding of the developmental mechanisms of
childhood.

It was Freud’s belief that by making the client’s unconscious processes known to them through analytic interpretation, they could develop new, more positive and functional ways of relating. He claimed: “If we succeed, and we usually can, on enlightening the patient on the true nature of the phenomenon of transference, we shall have struck a powerful weapon out of the hand of his (sic) resistance and shall have converted dangers into gains” (Freud, 1940: 177). Gradually Freud moved from the view that the analyst should act as a mirror, or scientific investigator without evidence of a personality, into a conviction that the analytic relationship could be used as a means of understanding the patient’s unconscious motivations and needs (Kahn, 1997). Encouraging and magnifying the transferential experience of the patient in such a way that analytic interpretations could be facilitated, he believed, achieved this. However, he remained firm throughout his career that countertransference, the unconscious communications emanating from the analyst toward the patient, could be eliminated through the personal analytic work undertaken during training analysis.

Perhaps because of Freud’s esteemed position within the analytic community, amongst whom he was known as The Professor, it was many years before the utility of countertransference was fully explored or recognised. Paula Heimann’s seminal 1950 paper On Countertransference is widely acknowledged to have structurally changed the working practices of psychoanalysts, who began to interpret their own thoughts and feelings towards their patients as possibly originating from the complex interplay between the unconscious communications of the two people in the consulting room, the patient and the therapist. Principally Heimann’s (1950) view differed from previous conceptualisations of countertransference in three discrete ways. First, it proposed that the entirety of the analyst’s feelings towards her patients could be considered as countertransference phenomenon; second and essentially, that countertransference could be utilised as a valuable diagnostic tool in the discernment of the patient’s unconscious processes; and third, that it could act as a response to the patient’s transferential feelings in a way not dissimilar to Klein’s (1946) conceptualisation of the process of projective identification in analysis.
Working with schizophrenic and paranoiac patients, Melanie Klein identified a phenomenon that often appeared to occur in patient-therapist dyads, and in particular with seriously troubled clientele. She suggested that there are parts of the self that the patient finds so disturbing that they cannot be contained and accepted as part of the self. These aspects are therefore split off from the self and projected into others, and, in the case of therapy it is the therapist who then assimilates the projected trait or traits. Consequently, the patient identifies the projection as having originated in the analyst. Segal succinctly states, “In projective identification parts of the self and internal objects are split off and projected into the external object, which then becomes possessed by, controlled and identified with the projected parts” (1973: 27). Young suggests that the response of the therapist to the projection is not one which is wholly alien or external to her experience but that they arise “from the general repertoire of that person’s potential feelings and gets (sic) exaggerated and expressed” (2000: 3).

My own first recognisable experience of projective identification occurred very early in my training when I was being observed by a psychoanalytic psychotherapist whilst conducting my first assessment on placement. However, I was not unaccustomed to undertaking assessments because the previous year I was on a placement at a centre working with eating disorders and my training had mainly focused on assessment issues. The client attending this particular assessment was a woman with two young children who sought therapy because of marital difficulties. I began by following the structure of the assessment format and I asked questions concerning her current difficulties, which she attributed solely to her husband. When asked about her early family history she recalled details of her husband’s early family life and when asked about any other personal biographical details she responded by providing details of her husband’s biography. Questions concerning her children were met with concern for herself and the terrible predicament she faced due to her husband’s inhumane treatment of her. About half an hour into the assessment I was overcome by a sensation of panic. My pen ran out of ink. I froze. I was overcome by the feeling that I’d got the wrong patient and, probably quite significantly, that I wanted someone to rescue me from her cold unwillingness to engage with me in the therapeutic process. My response to her was to become so remote and distant that I could see little point in
even beginning a relationship, let alone trying to sustain one. A more experienced or insightful practitioner might have been able to recognise this consulting room dynamic as an instance of projective identification. Although I wondered what had happened to deskill me in such a dramatic fashion I was unable to work with the projection in order to understand the feelings of the client and she left the interview, and to my knowledge the psychology service, never to return again.

Projective identification is one form of countertransference which finds its origins in the communications of the patient and that is why the opening quote by Searles concerning the patient reeling in the unconscious of the analyst is so appropriate to this phenomenon. Once the projection is identified however, the client’s hook is no longer quite so barbed and the analyst’s unconscious is free to float off and study the bait. It is this study that provides the analyst with the essential tools of insight and interpretation that, ultimately, are of such use to the client. Fortunately, I have had other experiences of projective identification, which I was able to utilise in the work, and, with the help of my supervisor, was able to work through in order to get a flavour of the client’s experience. One such case was a 38-year-old man who had been diagnosed with epilepsy at the age of 11. He had never had an intimate relationship with a woman and he said that he felt that this was an impossibility given his illness.

During several of our sessions I had a persistent but not overwhelming feeling that I might faint, although there was no reason why I should and I had never fainted before in any other circumstances. This so preoccupied me on one occasion that I was unable to attend to the session in the way that I normally would, however, I noted this at the time and asked if he was concerned that he might have a fit while we were meeting. He responded that it had been on his mind all that day and during some of our previous sessions. He said that if he did lose consciousness in front of me it would mean the end of our relationship because he could never allow himself to be seen in such a vulnerable way. He said that it was akin to being demasculinised. Fortunately, we were able to use this information to look back at snapshots of his development, and in particular to the circumstances of his early adolescence when he was diagnosed with epilepsy, to understand why he might attach such feelings of impotence to it.
Once the client’s fear of having a fit in my presence was communicated, my own concerns about fainting gradually evaporated.

In the first of the examples of countertransference provided, the experience was unhelpful to the client and in the second, it provided an aid to the client’s greater self-understanding. Racker (1957, 1968) identified both of these types of countertransference as impacting upon the therapeutic relationship. In the case of beneficial countertransference, Racker (1957, 1968) described an approximate union or identity between the experiences, impulses and defences of both the client and the therapist. He called this concordant identification and he believed that it resulted in empathic insights, which were facilitated by the analyst’s understanding of his own feelings towards his client. Racker (1957, 1968) also discussed a less useful type of countertransference, which he called complementary. This type occurs when the client represents an important object from the analyst’s past and the analyst treats the client according to his own previous experience of that object. This would, of course, mean that the analyst’s ability to empathise with the client was blocked by his own material. Racker (1957, 1968) believed that complementary and concordant countertransferences were closely linked in that any reproduction of the analyst’s past experience that was brought into the analytic situation would occur as a response to stimulus from the client.

This attempt to connect the two types of countertransference arose from a debate within the psychoanalytic community concerning how much or how little of the therapist’s feelings should be considered as countertransference. It was Racker’s view that the totality of experience should inform the therapists’ work and this is the conceptualisation that is most common in contemporary practice. It should also be noted that unless one has a firm grasp of Racker’s terminology the phrases he uses can be quite confusing and a number of clinicians have therefore subsequently modified the terms whilst leaving the underlying descriptions intact. One such practitioner is Kahn (1997) who simplifies the description of the concordant type as “useful” countertransference and the complementary type as “obstructive” countertransference. In practice, there are many ways in which countertransference can deter, hinder or otherwise frustrate positive therapeutic advancement and it therefore requires of the
therapist vigilant sensitivity to their own feelings, senses, attitudes and prejudices. This may be particularly difficult for trainee therapists, like myself, who occasionally feel flooded by both academic material and novel clinical experience.

For those who wish to enter into psychodynamic practice, this points to the need for a training analysis, which Freud passionately held to be vital to the budding therapist’s suitability to practice. In a paper that may have foreshadowed future understandings of countertransference, Strachey touched on the discomfort that a therapist may experience when leaving herself open to the vicissitudes of the client’s unconscious communications. He warned that “the giving of a mutative interpretation is a crucial act for the analyst as well as for the patient and he is exposing himself to some great danger in doing so” (1934: 159). This, he believed, is because the client’s id-energy is active, actual and unambiguously aimed directly at the analyst and therefore taps into the relationship that the analyst has with her own unconscious. Personal analysis facilitates therapists’ attunement to their own early scripts, developmental processes and internal objects so that they can discern what of the therapeutic material belongs to them and what has flowed from the client and then utilise that information in the client’s best interest.

It is perhaps relevant to note that this principle in not held in such regard in other areas of psychological practice, for instance in clinical psychology, where it is not thought necessary for practitioners to undergo their own therapy prior to becoming qualified to treat other people. If one accepts Young’s (2000) position that countertransference is alive in all human transactions - which incidentally is a view shared by others such as Sullivan, who, in 1953, described it as parataxic distortion - then surely it would be of benefit to any qualified clinician to have a thorough understanding of its effects. Perhaps then all trainee psychologists and psychotherapists should be required to experience some therapy themselves.

When an understanding of countertransference phenomena is lacking in the therapist, several unhelpful situations can arise. Analysts may under or over-emphasise issues according to their own scripts. For instance, a therapist who is sensitive to feminist issues may overlook the bullying a man endures at the hands of his female employer
or conversely, the same therapist may stress aspects of what she views as inequalities in a female patient’s marriage, which wouldn’t otherwise have been of concern to that patient. In my own practice such a distortion might have occurred when a female patient told me that she had left her two children and her husband ten years previously to pursue a career which she felt was of greater importance to her than her family. Although I was quite taken aback at this revelation, the woman expressed no remorse or regret and attended therapy in order to come to terms with the work-related stress she was experiencing. It was necessary for me to note that we ascribed to different codes of behaviour and that it was unhelpful to judge her by my standards. Of course there may be times when the clinician feels unable to work with moral differences, as perhaps in the cases of working with paedophiles or violent criminals.

The moral position of the therapist is extremely relevant to countertransference in the sense that it will at least in part be determined by superego functioning. According to Money-Kryle (1956), if the severity of the therapist’s superego is too great then she will be unable to tolerate her own failings and limitations. The therapist might then develop a sense of guilt or defend against such feelings by attributing blame to the client. In either case, the therapist’s ability to utilise the countertransference would be impaired and she may experience a sense of frustration or stupidity when there is a disruption to her concentration during a session. Thus, Money-Kryle suggests that the therapist’s three-fold task begins with the awareness of defensive strategies in oneself, moves onto recognition of the client’s role in arousing those defence mechanisms, and finally, there should be a conscious awareness of the effect this is having on the therapist.

Vigilant attendances to one’s own inner voice concerning feeling states about the client are essential to the use of countertransference. Pick believes that “constant projecting by the patient into the analyst is the essence of analysis” (1985: 37). The fundamental occupation of therapy is attendance to the countertransference in order to discover what lies beneath the client’s transference so that mutative interpretations can be made. Countertransference, therefore, is the essence of the therapeutic relationship.
References


In cognitive therapy, therapeutic change is not dependent upon the therapeutic system of delivery but on the active components that directly challenge the client's faulty appraisals. Discuss.

The above statement concerns the role of the therapist as an instrument of change in the client's cognitive and behavioural functioning. According to Clark, "the role of the cognitive therapist is to offer corrective information and experiences that realign individuals' interpretations so that they arrive at a more adaptive understanding of their personal reality" (1995: 156). What, then, is involved in the therapist's offering of this "corrective" information and experience? Is it the therapeutic system of delivery that leads to "more adaptive understanding" or is it the active components drawn upon in psychotherapeutic work that produce the beneficial effects?

In order to answer these questions, I will first define the key terms 'cognitive therapy' and 'therapeutic system of delivery'. A brief historical overview of Aaron Beck's (1976) development of cognitive theory and practice will then be outlined. This overview is essential to the discussion because the questions raised by the above statement move beyond the sole domain of cognitive therapy and reach to the very heart of contemporary debates concerning the delivery of psychological services to those in need. From this conceptual background will follow a review of research pertaining to the processes and agents speculated to be fundamental conditions of therapeutic change. This paper will demonstrate that the therapeutic system of delivery is itself a highly significant active component of change and that therapists use it in order to challenge clients' faulty appraisals. Moreover, it will be shown that the utilization of the therapeutic relationship is a practical skill that facilitates beneficial changes in clients' functioning.

Because the statement, and the debates that arise from it, strike beyond important considerations about how best to effect change in those who seek or require it, they enter the realm of the political and the historical. They are debates about how we have defined ourselves as psychologists in the past; about how we hope to be perceived as psychologists in the present and they have, of course, repercussions for
the future delivery of psychological services. In that sense, the changing face of psychology will have implications for its practitioners and for those who utilize their services as it moves toward the development of more adaptive practices and better-deployed therapeutic services in the future. This paper will therefore conclude with a discussion of the important issues raised by the above statement because they concern the profession of counselling psychology as it seeks to forge a public identity in this post-modern, post-structural era of conflicting theoretical ideologies regarding the very nature of science itself.

In its traditional form, cognitive therapy is an umbrella term for those therapies that offer a highly structured, problem-solving approach to clients' difficulties. Treatments are normally short-term and sessions are focused on assisting clients to identify, and subsequently to modify, their maladaptive and dysfunctional thought processes. Cognitive therapists believe that those who suffer from psychological distress or disorder have developed a system of faulty appraisals that maintain their disturbed or distressed psychological states through the selective abstraction of negative thoughts. Diaries are often kept in which clients note their negative automatic thoughts and attempts are made both during and outside of therapy sessions to challenge those thoughts with more positive, adaptive ways of thinking (Beck, 1996; Beck et al., 1979; Hawton et al., 1989).

The term cognitive therapy is often interchangeable with Cognitive Behaviour Therapy (CBT) as cognitive clinicians believe that adjustments to maladaptive behaviours will follow from, or arise concurrently with, more adaptive thought processes (Milton, 2001). Sometimes this change is speculated to occur in the reverse order and more adaptive behavioural patterns, particularly those occurring through environmental manipulations, can result in the modification of cognitive patterns (Hobbs, 1962). Thus, the skilled cognitive therapist relies on her training and experience of maladaptive, and sometimes distorted, thought processes in order to meet the often-creative challenge of enabling the client to re-evaluate faulty appraisals in favour of more functional means of thinking and, by extension, of being.
The therapeutic system of delivery employed for the purpose of advancing this work could refer to two fundamental psychotherapeutic concepts – the therapeutic relationship, often called the therapeutic or working alliance in cognitive therapy (although in practice the terms relationship and alliance are often used interchangeably); and the therapeutic frame, aspects of which are sometimes described in cognitive terms as ‘therapist proxemics’ (Goldstein, 1974; Morris & Magrath, 1983). Because the contribution of the relationship to the therapeutic endeavour is the more rigorously debated of the two notions, it will form the primary focus of this paper. In cognitive therapy, the relationship is often defined as the collaborative partnership developed between therapist and client (Jacobson, 1989; Lambert, 1983; Overholser & Silverman, 1998). It is a relationship based on the notion of collaborative empiricism in which the client and therapist work together to test out the client’s predictions, assumptions and beliefs about himself and the world (Arnkoff, 1983; Clark, 1995; Horvarth & Greenberg, 1994).

However, the therapeutic relationship has not always been, and is not always now, conceptualised in those terms by psychologists. Historically, the therapeutic relationship arose as a fundamental and critical concern of psychoanalysis (Freud, 1913). Freudian theory postulates that the hidden or secret - and potentially problematic - desires of the child begin with the Oedipal Complex at the age of about three when undesirable wishes or impulses are repressed from conscious thought. It is these repressions that form the basis of ongoing dysfunctional behaviours as the client is believed to respond in therapy according to a pattern of behaviour established in relationship prototypes learned in early childhood. However, the client is said to be unaware that they have developed these relationship structures and, often because of childhood trauma, they are believed to repress the knowledge of their own defensive functioning. Theoretically, when these relational styles are presented to the client they bring greater understanding of the nature of their own behaviour and a choice can be made as to whether or not to initiate change. Ultimately, the central task of psychoanalytic or psychodynamic therapy lies in uncovering what has been repressed and buried in unconscious thought.
Differences in the systems of delivery used by cognitive and psychodynamic therapists therefore converge upon the centrality of the relationship as an instrument of therapeutic change. As an element of change, the emphasis placed upon the relationship by individual cognitive therapists is, at least to some degree, elective and idiosyncratic and thus is likely to vary considerably from practitioner to practitioner; but, the overwhelming majority of psychodynamic practitioners will regard their relationship with the client as the site of richest reward in their quest to enhance their clients' lives. This disparity of approaches did not arise as an accidental by-product of disparate psychological enquiries. Rather, many of those initially involved in the development of the cognitive model of treatment first trained as psychoanalytic practitioners (Milton, 2001).

Aaron T. Beck, who could be described as the founding father of CBT\(^1\), was one such clinician. Following his training as a psychoanalyst, he became disillusioned with the emphasis that psychoanalysis placed upon infantile psychological development and unconscious processes (Milton, 2001). Additionally, Beck (1976) sought to expand methods that were outside of the treatment realm of behaviour therapy and which imposed much greater focus on the client's immediate problems than did psychoanalysis.\(^2\) He took as a starting point for his therapeutic developments the assessment of his own depression and somatic phobias (Weishaar, 1993). Beck (1976) proposed a theory of emotional disorders that detailed the mechanisms actively maintaining problematic cognitions and behaviours, together with a manualized system of treatment that offered specific and detailed instructions about how to challenge them. He therefore relocated the focus of psychotherapy from more global, complex relational issues onto the practical management of symptoms occurring in the everyday lives of those affected by psychological difficulties. Speculations about deep, inner psychic processes like the unconscious drive to repeat relational patterns were eschewed in favour of the use of pragmatic techniques in which therapists could take a 'hands-on' approach to problems, offering information, guidance and advice to their clients.

\(^1\) Other important contributors to the model were Albert Ellis (1972) and Donald Meichenbaum (1985).
\(^2\) Although at this time behaviour therapists had experienced some success in the treatment of phobias, they had made little impact in other areas of psychological disorder, like depression. See Rachman, (1996) for a discussion of the contribution of behavioural techniques to cognitive therapy.
From its early development, theories of CBT drew upon the 'information processing' model of memory that influenced psychological investigations of the time. This, together with its advantages as a model that required relatively fewer resources than psychodynamic therapy, was perhaps why many psychologists so enthusiastically embraced it. Less training was needed in order to practice CBT and courses of treatment could be completed in weeks or months rather than in years. In addition to being a cost-effective approach to psychological care, it also had particular appeal in the public health care sector because it could easily be incorporated into the medical model of treatment. Outcome studies have shown that CBT is an efficient and efficacious treatment and, according to Salkovskis, “cognitive therapy has become the single most important and best validated psychotherapeutic approach” (1996: xiii). Further, he concluded that Beck’s understanding of emotional problems and his focus on symptomology represented a paradigm shift that had important repercussions for psychotherapeutic practice and that now, ‘the paradigm has truly shifted’ (1996: xiii).

So, are the research results really so unequivocal as has been suggested and if so, what makes CBT such an effective form of treatment? Consistently, meta-analyses comparing different forms of psychotherapy have shown little actual variation in therapeutic gains across treatments but appreciable gains for psychotherapy compared with control groups (see Luborsky et al., 1999; Smith & Glass, 1977; Stiles, et al., 1986; United States Department of Health and Human Sciences, 1993). Following their meta-analysis, Bergen and Garfield (1994) concluded that, “We have to face the fact that in a majority of studies, different approaches to the same symptoms, (e.g. depression) show little difference in efficacy” (1994: 822). It therefore seems highly probable that the most beneficial components of psychotherapy are those common to all forms of therapeutic treatment.

Further research into the variables consistent across all of the major therapeutic approaches has shown that the working alliance is probably the single most important factor in therapeutic outcome (Horvarth & Symonds, 1991; Luborsky et al., 1999; Orlinsky & Howard, 1986; Stiles et al., 1986). Horvarth and Greenberg have been particularly interested in the study of the therapeutic alliance believing that, “the alliance is currently the best model of the in-therapy, pan-theoretical process variable”
The majority of practicing therapists today, with some notable exceptions, accept that a generally positive working alliance is a necessary condition of therapeutic change. Amongst those exceptions, for instance, is Albert Ellis who developed Rational Emotive Therapy. Ellis (1999) disagrees with the research findings mainly because of the self-report measures employed in most of the investigations into the working alliance. He argues that merely because clients report feeling better does not indicate that they actually are significantly better. In Ellis’s view psychological improvement does not occur unless the main presenting symptom is reduced, together with other related symptoms. This improvement in symptomology should be maintained for several years even when the client experiences major and severe adversity in their lives, according to Ellis (1999).

However, Ellis’s (1999) assertions do not take account of research evidence indicating that therapists whose qualities of warmth, genuineness and empathic understanding achieve more positive therapeutic results (Bachelor, 1991; Foreman & Marmar, 1985; Luborsky et al., 1985; Marziali, 1984). A number of alliance scales have been developed for the purposes of isolating specific alliance components and these include the Penn Scales (Luborsky, 1976), the VPP/VTAS (Gomes-Schwartz, 1978); the TAS (Marziali et al., 1981), the CALPAS/CALTRAS (Gaston, 1991) and the WA1 (Kokotovic & Tracey, 1990). Common to these scales, two components were found to be the best predictors of positive therapeutic outcome. They are the personal attachment or bond established between the therapist and the client, and the collaboration or willingness of both parties to invest in the process of the therapy. Jacobson has concluded that, “the therapist-client relationship is often systematically utilized to bring about changes in core beliefs and underlying assumptions” (1989: 88). Safran concurs with this view, and emphasizes, “any ‘relationship act’ is ultimately a cognitive intervention” (1990a: 119). In other words, the therapeutic relationship - or what might be called the therapeutic system of delivery - is an active component that is utilized to directly challenge the client’s faulty appraisals.

The statement under discussion could therefore be viewed as a problematic one. Despite evidence to the contrary, it assumes a dichotomy between the system of therapeutic delivery employed to effect therapeutic change and the practical skills
utilized to challenge faulty appraisals. In fact, the importance of relationship factors to psychotherapeutic change has been so widely assimilated into the culture of psychological practice that major adaptations to the original CBT model have resulted in the recent development of several new and innovative therapies. These include Schema-focused Therapy (see Safran, 1990a; 1990b; Padesky, 1994; Young, 1990), Cognitive Analytic Therapy or CAT, (see Denman, 2001; Ryle, 1995), and Dialectic Behaviour Therapy or DBT, (Linehan, 1993). Not only do these psychotherapies emphasize the importance of the therapeutic relationship, they all incorporate psychoanalytic notions into their principles. Schema-focused work, for instance, utilises the notion of the patient's 'hook'\(^3\) in order to discern the particular interpersonal 'pull' or pattern that emerges in the therapeutic relationship (Safran, 1990a). Similar to the theory of psychodynamic therapy, clinicians using a schema-focused approach believe that this pattern of relating is problematic for the client outside of the consulting room. This type of therapy was developed specifically for clients with highly complex and lifelong problems, such as personality disorders. It is therefore not uncommon for schema-focused therapy to take a long-term approach, extending over several years. CAT incorporates psychoanalytic principles, like transference and countertransference, whilst also emphasizing cognitive procedures such as the completion of homework tasks. A feature of DBT is the Kleinian psychoanalytic notion of 'splitting' in which the patient displays dichotomous thinking and this model too was developed for those with complex psychological difficulties.

Major criticisms have been levied against standard CBT because of its failure to incorporate some of the more basic psychoanalytic principles into its original theory. Although Clark (1995) is a CBT practitioner and advocate, he acknowledges that CBT has fundamental limitations and he summarises these as follows: it ignores the therapeutic alliance; it fails to recognize unconscious processes; it has a limited view of human emotion; and its practitioners have an inadequate understanding of the impact of interpersonal factors. All of these failures of the CBT model are inter-

\(^3\) The use of the term ‘hook’ was first expressed and developed in 1958 by Harold Searles in order to describe the psychoanalytic notion of countertransference (ie. the way in which patients elicit particular responses from their therapists). He began his elaboration of countertransference with the words: ‘The patient’s hook catches its fish in the analyst’s unconscious and reels it in’ (p247).
related and their recognition is an acknowledgement of the importance of psychoanalytic principles to the enhancement and further development of psychotherapeutic practice. In fact, it was the recognition of the importance of relationship factors to psychotherapeutic practice and outcome that led, over a decade ago, to the creation of the Division of Counselling Psychology within the British Psychological Society. Many within the Division subscribe to the view that aspects of the relationship that result in the most significant and enduring improvements to the client’s psychological well-being cannot be isolated, specified or quantified by scientific study (Spinelli, 2001). Spinelli believes that it is the “special and specific ‘moments’ in the therapy when the client and therapist experience an authentic person-to-person connection that alters the relationship and, as a consequence, the client’s sense of self” (2001: 7).

It is this interpretation of the therapeutic relationship as a meaningful encounter that defies scientific measurement, which is at the heart of recent deliberations in counselling psychology. On the one hand, currents trends within the NHS towards evidence-based practice mean that psychologists are increasingly called upon to demonstrate the effectiveness and utility of their chosen approaches. Scientific documentation of the component factors of therapeutic change is likely to be an unavoidable corollary to contemporary practice, particularly where there is competition amongst and within psychology departments for resources. Therefore, it could be argued that the scientist-practitioner model needs to inform the ethos of counselling psychology. On the other hand, there are convincing arguments that this model reduces the complexity of emotional distress and psychological disturbance into simplified, knowable and isolated variables wherein individual identity is collapsed by group averages (Kaye, 1995; Stern et al. 1998; Williams & Irving, 1996).

The debate therefore concerns whether or not we believe that the relationship we offer our clients is greater than the sum of its component parts. If the answer to that question is yes, then the value that counselling psychologists place on their identities as paradigmatically quantitative scientist-practitioners may be somewhat diminished. Former chair of the British Psychological Society’s counselling psychology division, Pam James, has stated, “there is a need to clarify who we are and what we do” (2001: 24).
2). In addressing that concern, it should be remembered that qualitative research methods attempt to honour the voice of individual clients and their perceptions of self-experience. So, although the uncapturable aspects of human interaction limit our investigations, qualitative psychological research can contribute to our understanding of what works in therapy. Criticisms of traditional CBT approaches and their reliance on a realist paradigm have led to the development of integrative therapies like schema-focused work and DBT. Qualitative psychological studies, focused as they are on the subtlety of human relationships, may also yield further advancements in the services counselling psychologists are able to offer their clients.
References


the depression guideline panel, (pp. 71-123). Rockville: AHCPR Publications.


The Dialogic Unconscious: The Missing Link or a Contradiction in Terms?

"It is not the therapist's theoretical orientation that is as crucial in the healing process, as is the wholeness and availability of the self of the therapist."

Hycner (1991: 12/13)

The above quote has been chosen as a starting point for this paper because I do not intend to claim that the approach on which my theoretical stance is based, and which supports my clinical work, is a conclusive end product of study or that it in any way reflects an 'answer' to the struggles faced in therapeutic encounters. Rather, it provides a fluid, adaptive framework for the investigation of the client's distress, their needs and their preferred lifestyles and choices. In that sense, the notion of the 'dialogic unconscious' - the approach that informs my theoretical and clinical integration of models - provides a lens through which attempts to focus attention on the client's lived experience can be made.

The dialogic unconscious brings together one of the core clinical theoretical models taught on this course, the psychodynamic approach, with one of the core theoretical research epistemologies also taught on the course, the discursive approach. Developed in 1997 by Billig, the dialogic unconscious represents the integration of two quite diverse psychological schools. Theoretically influenced by aspects of philosophy, sociology and linguistics, discursive psychology is underpinned by a social constructionist perspective. This perspective can be identified by four essential characteristics: it questions the taken-for-granted assumptions on which conventional knowledge is based; it views ways of understanding as being historically and culturally relative; it considers 'truth' to be constructed in social process and, it understands social actions as being conjoined with systems of knowledge (Burr, 2000). Normally, discursive psychology constrains investigations of constructs like the mind and the unconscious. Instead, it looks to the socially occasioned nature of speech acts to account for psychological phenomena. Language therefore takes centre stage as the medium through which people make sense and meaning of the world around them.
On the other hand, psychodynamic practitioners, and in particular adherents of the Freudian model, privilege investigations and speculations concerning the mind, accepting as ‘facts’ the universality of psychological processes and mechanisms. For instance, every child at the ‘oedipal’ age of about three is presumed to negotiate a psychological, and sometimes a physical, state of sexual desire for the parent of the opposite sex. In therapy it is often speculated that developmental problems arising from such negotiations underlie adult psychological ‘dysfunction’ in such a way that problematic behaviours are repeated within the therapeutic relationship. Freud (1924) called this a ‘compulsion to repeat’.

In the dialogic unconscious, Billig (1997, 1999, 2001) brings together these apparently conflictual approaches and bridges their theoretical differences. Fundamentally, he is concerned with maintaining a social constructionist stance. However, Billig argues that the discursive approach fails to account for what is left unsaid and he suggests that he has found an explanation of this in Freud’s theory of repression. According to Freud (1915, 1924), repression occurs when thoughts, ideas or impulses are not allowed into conscious awareness because they would be a source of anxiety or distress. Billig (1997, 1999, 2001) appropriates the concept of repression and, applying it to discursive acts, contends that language has repressive as well as expressive possibilities. Initially, the performance of repression, he maintains, is learned throughout childhood mainly through parental attempts to teach children how to suppress rudeness and how to conform to the rites, rituals and customs of speech that maintain and replicate cultural prescriptions of politeness or, what Garfinkel (1967) termed, ‘everyday morality’.

This understanding of discursive practice had strong resonance with my own nascent conceptualisation of dynamic social interaction. But, why should that be when the merging of the two ideologies appears to be so untenable? It is their very incompatibility that explains the attraction to this model. Like salt and vinegar, the distinctive flavour of each theory combines to make more palatable what might otherwise seem appealing but unseasoned or incomplete. The reasons why I attempt to combine these two seemingly inconsistent approaches are most likely related to my own personal history and experience. According to Larsen (1996), all psychological
theories are a reflection of their creators' life experience. Of course I do not claim to have hit upon the notion of the dialogic unconscious myself but, like all therapeutic practitioners, its interpretation and application are a reflection of my own idiosyncratic reading of it.

For a number of years, several times a week, I took my place on the couch for psychoanalytic psychotherapy. This experience was foundational to my current view that the 'undoing' of repression is probably the single most crucial aspect of the therapeutic encounter. In therapy I had a voice that was not permissible in any other time or in any other space and it was this discursive freedom that was the amalgam binding my therapist and myself to each other. It would be misleading to suggest that I had the courage to fully embrace every opportunity for self-disclosure but as time passed so too did my reluctance to explore what might elsewhere be socially prohibited. According to Milton (2001), when the client reaches the stage of being able to say whatever they like to the therapist they probably no longer need therapy. This supports the conviction that what cannot be said is particularly salient to the therapeutic endeavour.

Many psychodynamic clinicians would concur, arguing that by examining the client’s unconscious communications, their defensive repressions can be exposed whereupon they can begin to be cured of their individual psychopathology. However, when the client’s self-identity is seen as multiple, fragmented and changeable, as well as being historically and culturally dependent, then the 'undoing' of repression takes on diverse meaning and purpose. Selfhood can be explored and experienced in new and alternate ways as discursive possibilities are broadened. One of the dictums of Billig's (1997) theory is that linguistic rules learned for the production of conversation with others will match those used in the production of inner dialogue. Therefore when the habits of external speech are changed and new voices emerge in conversation with the therapist, it follows that changes, however gradual, will naturally occur in unspoken, self-talk, potentially providing the client with a more positive experience of their inner and outer worlds.
How might this work in practice? Both psychoanalytic therapists and discursive psychologists attend as closely as possible to what, precisely, is said in conversation - the therapist using process notes and the discursive psychologist analysing transcriptions of dialogue. The process in both cases is similar, as the respective practitioners examine not merely the content of the spoken words but what the speaker is accomplishing by uttering them. In working with the dialogic unconscious it is also necessary to attend to the process and to explore the ways in which a client might attempt to shut down or close off areas or topics of conversation. By attending to this process, therapists can become aware of how a client will construct themselves as a moral being by reproducing the customs of speech which, for them, conform to the cultural prescriptions of everyday morality.

Moral positions are therefore accomplished between the client and therapist as each utilises their own familiar, discursive frameworks. It is the tension that arises between these two frameworks that facilitates and draws out the meaning and importance of specific discursive repressions for the client. In other words, the freedom offered within the therapeutic space can be used as a means of altering the client’s perception of what he is permitted to say, and also how and when it might be said. For instance, in mundane social conversations a pause of more than a second normally poses a problem for speakers (Jefferson, 1989) however, in the therapeutic encounter longer silences are tolerated in order to indicate that the client has a greater share of speaking time (Sacks, 1989). The client’s response to silence in therapy may reveal something about their ability to adapt to contexts where the rules of discourse shift in unfamiliar or seemingly unusual ways.

How the dialogic unconscious has informed my therapeutic practice might be best illustrated by a clinical example. Mr Fischer attended therapy with symptoms of anxiety. He was unable to endure being in public place like sandwich bars, cafés or train stations. He was also finding sleep difficult and he would spend much of the night ruminating on thoughts about his boss whom he disliked or about his weight, which, although it was average, he considered to be too high. These difficulties were detailed and explained as unwanted but at the end of each description he would claim

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1 The client's details have been altered to protect confidentiality and the name used is a pseudonym.
that they were "not a problem". The story he told of his life was filled with sadness, loss and frightening drama. From his earliest memories his father had been physically violent and psychologically aggressive toward his mother. When he was aged ten, Mr Fischer was admitted to hospital with near-fatal renal failure and put on a life support system. The following eight years of his childhood were taken up with inpatient and outpatient care and medical interventions and then, three weeks after his consultant discharged him, his grandfather died. Yet, all of these events were "not a problem".

I asked myself what Mr Fischer might be doing by uttering these words and I realised that each time I was prevented from pursuing that particular area of conversation more fully. If it wasn't a problem then there was no need to talk about it. Rather than isolating our relationship and focussing on potential problems between us - as might have been done in psychodynamic therapy - we explored what it would mean to him if these childhood experiences were a problem. How would things be different? Mr Fischer talked about listening to his father beating his mother, over-hearing his consultant tell his mother he was near death, and learning only hours beforehand that his grandfather was about to die. These difficulties had been managed in his family by silence and denial of pain. He believed that it was acceptable to say what had happened to him but to open these events up for discussion was too threatening. Token acknowledgements could be made but there was an unspoken code prohibiting any further dialogue.

Gradually Mr Fischer began to talk more about his vulnerability – both physical and psychological – and eventually he was able to voice the thought that he had probably been repressing for the greater part of his life. He said that he was to blame for his father's violent outbursts and for the pain that this had caused his family. He added that everyone would have been better off if he had died that day in hospital. Mr Fischer's saying of what, for him, had previously been unsayable was a mutative experience. From that point he was able to begin to speak about himself in ways that were more reflexive about issues of blame and responsibility. The opening up of discursive possibilities unsettled Mr Fischer's previous assumptions about himself and allowed him to ponder alternative identities.
Of course like any client, Mr Fischer’s case might be formulated in any number of ways, utilising a variety of approaches. Both the psychodynamic approach and the dialogic unconscious take a developmental perspective but departures in focus arise when constructions of meaning rather than presumptions of ‘compulsion to repeat’ are privileged in the therapeutic encounter. To return to the statement at the beginning of this paper, the availability of the self of the therapist is perhaps more important to the healing process than is the particular approach of the therapist. Therefore, the therapist’s struggle to provide clients with the best possible outcome may lie in identifying the approach that is, for them, most wholly self-utilising. For me that approach is often the dialogic unconscious. From it I can draw upon my own experience of therapeutic discourse and it’s corollary of psychological freedom and change, together with preserving my theoretical commitment to the endeavours of social constructionism. Far from being a contradiction in terms, the dialogic unconscious provides a complimentary link between my personal processes and professional doctrines.
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Out of His Mind:  
How Freud’s Thinking Helped to Set the Context  
of Counselling Psychology

Freud said human cognition could be either realistic or fantastical. How has this two-fold distinction influenced the context of counselling psychology and is it adequate to our understanding of the client?

Freud (1924) maintained that human cognition was either entirely realistic or entirely fantastical. This paper will explore how this two-fold distinction has influenced the context of counselling psychology and whether or not it is adequate to our understanding of the client. For many years, psychologists tended to accept that the distinction between ‘reality’ and ‘fantasy’ was concrete and immutable (Edwards, 1997), as did Freud (Gay, 1989). Reality, they suggested was comprised of physical, social and psychological materials that exist and have independent properties in the world regardless of any theoretical discourse or varying concepts about them (Greenwood, 1989). This reality was held to be observable and definable through strict adherence to scientific methods (Feigl, 1970) and assertions that could not stand up to such scrutiny were considered to be unscientific. Fantasy, on the other hand, referred to the conceptualisation of that which is not immediately apparent, whether objects, symbols or events. ‘Pathological fantasy’ was believed to develop from the tendency to withdraw from, rather than accept, ‘reality’ (Reber, 1995) and this perspective prevails in many therapeutic settings today. According to the predominant ideology of Freud’s time, fantasy often tended towards the pathological (Puttnam, 1978) and Freud came to regard it as a defence mechanism through which unsatisfied needs could be gratified (see A. Freud, 1966).

In developing his ‘talking cure’, Freud made a significant contribution, not only to the foundational framework of psychoanalysis, but also to the context in which that analysis is set. For the purposes of this discussion, context primarily refers to the broad macro-level structure of counselling psychology and it concerns an analysis of theories and epistemologies, which ultimately situate people within particular therapeutic settings. These settings occur at local, micro-levels and might include GP’s surgeries, NHS psychotherapy or psychology units in hospitals as in-patients or
outpatients, private clinics, voluntary agency services or within religious counselling practices. The context in which Freud developed his distinction between ‘fantasy’ and ‘reality’ will first be discussed, as it is historically relevant to contemporary therapeutic settings. Challenges to the Freudian model of scientist practitioner will also be considered, particularly the social constructionist approach that regards truth as a fluid, subjective concept.

Freud's own background

Freud's own contribution to the field of psychology relied upon assumptions that arose from the combination of his scientific background and his position of relative social power. Most importantly, these factors were complemented by a broad and fertile imagination and together fuelled his insights into the mechanisms that, he speculated, drive human consciousness. For this reason, Freud's own history provides a pertinent background to the development of the medical model generated by a realist scientific epistemology. The empirically based scientist practitioner model still remains at the forefront of psychology in the fields of theory, practice and research today. Primarily, Freud considered himself to be a scientist (Ewen, 1994), but at the same time, didn't conform to all of the strict requirements of the Popperian scientism that began to dominate during his period of practice (Bowlby, 1969). In choosing not to use falsifiable methods for instance, Freud can be identified as holding an elitist position within the power structure that created those methods. Social positions are enabled by the historical and cultural context in which one lives (Foucault, 1974) and by the power ascribed within that context (Parker, 1996), and these, combined, dictate perceptions of what is real (Shotter, 1995). Fisher believes that, “a self defined by social and political processes or voices or descriptions of sociological power roles, is one defined by ascriptions of privilege” (1995: 396). Freud held a position of privilege, first within his own family and subsequently, within the scientific community that ascribed to his theoretical positioning (Morea, 1990; Storr, 1989).

In constructing his theory of psychosexual development for example, Freud (1953) related stages of oral, anal and genital bodily functions to interpersonal family relationships and dynamics, taking the perspective that these are stable features of each human being that influence psychological development. The irony of Freud’s
argument is that he relied upon a position based on realist, empirical traditions of scientific observation while at the same time his own position of power exempted him from strictly adhering to the conventions of that tradition. By positioning himself in such a way, Freud was able to successfully create a new scientific ‘reality’, that of the genesis of psychosexual development and the efficacy of transactional psychoanalysis in the treatment of its disorders. Freudian interpretations of psychosexual development still remain an important part of the treatment agenda in many medical settings in which psychodynamic therapy is offered and it also informs much of the curriculum of trainee counselling psychologists, including my own training on the PsychD Psychotherapeutic and Counselling Psychology course.

The Development of Freud’s Theories
The treatment of ‘pathologies’ and the understanding of human behaviour generally were shaped by Freud’s development of constructs like, the id, the ego and the superego. According to Mead (1934), the mechanisms of reflective thought - the combining of such processes as imagination with an epistemology - are a fusion of the contextualised framework within which one is socially situated, together with the unique character of one’s own local circumstances. It is the combination of situatedness and self that often defines an epistemology (Shotter, 1992) and Freud subscribed to that of scientist practitioner. Science, in its turn, rewarded Freud’s endeavours by adopting his views as part of its own evolving epistemological stance and hence, from a perspective that was based at least in part on his own constructions, new ‘realities’ like that of the id, the ego and the superego were formed. The scientist practitioner was ascribed an exalted position at the macro-level of scientific investigator, and, as will be illustrated later, at the micro-level of ‘knowing guru’ in relation to individual clients.

The scientist practitioner sought to understand and interpret human behaviour in such a way that made sense of people’s attitudes - for instance concerning sexual conduct. Freud’s theory of psychosexual development was one that explained gay and lesbian sexual practice as a psychopathological consequence of the failure to overcome infantile fantasies related to the resolution of oedipal impulses. In harmony with the prevailing social perspective of the time, gay sexuality was viewed as a perversion.
arising out of the ‘wrong’ sort of fantasies and some subsequent psychological treatments included the use of aversion therapy in the form of pornographic images of women and the use of female surrogates (see Masters and Johnson, 1979). The introduction of ‘homosexuality’ as a classification within the American Medical Association’s Diagnostic and Statistic Manual of the American Medical Association (DSM) located gay men and lesbians within the context of the mentally ill. Its removal as a diagnostic category in 1973 not only illustrates how, at a micro level, social notions affect the context of the medical reality into which a person is fixed at a particular historical juncture, but at a macro level it demonstrates that the theories themselves are grounded in prevailing cultural attitudes. Although most counselling psychologists would not now attempt to provide a ‘cure’ for ‘homosexuality’, many who subscribe to Freudian ideologies continue to consider this sexual orientation as a developmental failure (see Dean and Lane, 2001, for a review).

Challenges to Freud’s Approach

Not surprisingly, Freud’s theories have been criticised as damaging to large segments of society (Masson, 1990; Millett, 1970; Mitchell 1974). One of the main criticisms rests in the position of power that he ascribed to the analyst as mediator in the discernment of truth and fantasy in psychoanalytic settings (Masson, 1990). In the case of his patient Dora, Freud initially responded positively to her distress at having been sexually abused in childhood but he later conducted a famous U-turn dismissing her claims as the product of her own maladapted sexual longings, essentially as being nothing more than fantasies (Chodorow, 1991). This U-turn effectively empowered all analysts to disbelief their patient’s reports regardless of whether they had accurately recalled actual events (Storr, 1989; Masson, 1990). The two-fold distinction between fantasy and reality was therefore maintained without regard for the client’s own concerns (Ussher, 1991). Much of the process of psychoanalysis and psychodynamic psychotherapy is still predicated upon the notion that the client’s unconscious fantasies about the therapist need to be explored and resolved in therapy.

Women and ethnic minorities, particularly those not conforming to a conventional heterosexual orientation, comprise the majority of those treated for psychological disorders (Armitage et al, 1979; Goudsmit & Gadd, 1991; Goudsmit, 1994). Sayce
(2000) believes that there is a direct link between common racial discrimination and perceptions of those diagnosed as mentally ill. She cites the graffiti daubed on a street where a mental health service was planned to open: ‘Schizophrenics go home’ as having parallels with racist invectives that voice similar sentiments towards black people. Again, it could be argued that social attitudes converge with psychological theory to formulate medical ‘truths’ - in the above case regarding psychological perceptions of black minorities as being more ‘mad’ than white people.

Young (1996) argues that sexual representations of black men and women have their roots in white, colonial fantasies, which sought out signs of physical difference as being the antithesis of an idealised white ‘self’. According to Fanon, the debased desires of white men for participation in illicit sexual acts like incest and rape are projected onto blacks in such a way that, “the white man behaves ‘as if’ the Negro really had them” (1986: 176). White men’s fantasies thus become the ‘reality’ of black sexuality upon which stereotypes of black behaviour are transfixed. These stereotypes are aided by psychoanalytic and psychological perspectives, which set out to demonstrate the biological basis for such beliefs (Gilman, 1985). In this way, the distinction between reality and fantasy could be said to be blurred but made to appear scientifically clear through the construction of a reality for socially marginalised people, based on the fantasies of those in a more privileged position and reified by the theories of scientist practitioners. Those placed within the context of the mentally disturbed therefore perform the social function of maintaining the status quo by departing from conventions of normality (Foucault, 1974).

Similarly, stereotypes of women have informed medical practice such that they too have been psychologised, according to Goudsmit, who suggests, “women’s illnesses are assumed psychosomatic until proven otherwise” (1994: 76). She, and other feminist writers (see Hepworth, 1999; Showalter, 1997; Ussher, 1991), argue that the ‘medical gaze’ has historically pathologised women. Women’s reproductive systems were perceived as problematic in physical ways, which, it was professed, had simultaneous emotional and psychological consequences. It was not uncommon in Freud’s day for women with gynaecological problems to be viewed as mentally ill (Bordo, 1993), and Freud admitted his own lack of insight when he described women
as 'the dark continent'. Having focused upon women as problematic, the medical establishment has however been unable to demonstrate any inherent or convincing physiological weaknesses based on biology. But, with the aid of Freud’s theory of psychosexuality which posited a developmental defect based on gender alone, the medical ‘gaze’ was fixed on women’s minds, where, according to treatment statistics, it has rested ever since (Chesler, 1987).

Although some psychologists and psychoanalysts have resisted Freud’s interpretations of the ‘female mind’, others have employed psychoanalytic theory to account for the contribution of patriarchal values to women’s distress. Chodorow, 1991; Orbach & Eichenbaum, 1995; and Mitchell, 1974, among others, use Freudian analytic theory to explain women’s tendency to present for mental health services more frequently. Developmental difficulties, they suggest, culminate in psychological suffering that centres on relational issues and especially those concerning the mother/daughter dyad. However, this theorisation has had little impact on the numbers of women presenting for psychological care, and there has been an increasing trend towards women caring for women and female specialists in women’s psychological treatment (Ussher, 1991). This has taken the form of, for instance, The Women’s Therapy Centre, set-up by Eichenbaum and Orbach in the 1980’s, famous for its connection with the bulimic problems of Princess Diana. To put women’s treatment into context then, Freudian theory significantly contributed to the modern-day view that women are psychologically defective and therefore the establishment of treatment centres, both public and private, has been fuelled by women’s perceived greater vulnerability to psychological distress.

**Psychological Care Then and Now**

Historically, psychoanalysis was conducted in private, often at the home of the practitioner, with diagnosis and treatment occurring within a setting of relative privacy. This was a costly and time-consuming process, normally confined to the upper and middle classes. However, with the introduction in the 1980s of political measures to ensure that health care facilities offered patients a comprehensive service, counselling and psychological treatments entered the primary care agenda. Since that time, more than a third of all GPs surgeries are believed to offer a counselling service.
with the result that psychological care is now, more than ever, a public affair (East, 1995). Assessment, diagnosis and treatment of psychological problems have increasingly become part of patients’ primary care documentation as psychological histories are recorded in tandem with medical notes.

Often, psychological disorders are evaluated according to a reality testing in which the patient is meant to provide accurate inferences concerning perceived external realities. The classic symptoms of such ‘psychosis’ may be defined as regressive behaviours, extreme mood, hallucinations, delusional thoughts or beliefs or incoherent speech. In the medical literature, these disorders are often listed as schizophrenia, mood disorders, organic mental disorders, brief reactive psychosis or bipolar disorder. The DSM-IV and the World Health Organisation’s classification of mental and behavioural disorders (ICD-10), as the main diagnostic tools for the classification of mental pathologies, have far-reaching consequences for anyone under psychological scrutiny. The descriptions within the manual can be pivotal for the client as they ultimately determine the context into which they are placed or, whether they will be provided with a service at all. That DSM-IV and ICD-10 criteria can be interpreted variously by diagnosticians, and with disturbing repercussions for the client, has been widely debated (Parker, 1999a). Yet, the distinctions that they make form the basis of most treatment schedules for care and inform almost all contexts in which that care will be offered.

As Foucault (1974) suggested, maintaining social, political and economic power relations depends upon maintaining cultural divisions, including the separation of those deemed to be sane from those categorised as mentally ill. The distinction between those who have ‘psychosis’ and those who do not, provides the background against which diagnosis can be made and which will determine the context into which the ‘ill’ person is placed. From the early 1960s, R. D. Laing criticised the ‘Us’ and ‘Them’ categories that positioned schizophrenics as polarised and opposite to the rest of a sane society. Recognising the difficulty of maintaining such distinctions, Farber offers for consideration an incident that occurred between a schizophrenic patient and his ‘mad’ psychotherapist. The psychotherapist loaned a favourite pen to his institutionalised patient but was unable to convince the patient to return it. He
therefore broke into the unsuspecting patient’s room and retrieved the pen whilst the startled man was pinned securely to the floor by a pair of burly attendants. The psychiatrist parted with his patient’s words, “My, God, what a madhouse! All this fuss about one little fountain pen!” (1972: 82) ringing in his ears. The point here does not really concern who is the crazier of the two, but of the necessity of divisions in reinforcing power structures. As keepers of the diagnostic tools, the DSM-IV and the ICD-10, psychiatrists and to some extent psychologists, are armed with the weaponry of knowledge and become the arbitrators of sanity. Depending on the perceived severity of the ‘cognitive impairment’, those classified as having a psychotic disorder can be treated with surgery, pharmaceuticals and various types of psychotherapy or combinations of the three in a wide variety of contexts, sometimes under section and therefore without the person’s consent.

### The Multi-Levelled Psy-Complex

Parker believes that “diagnostic systems are fragile things without systems of power to hold them in place” (1999b: 107). He suggests that the DSM-IV and the ICD-10 depend for their power on quite narrow conventions of a local historical, cultural and subcultural nature. Taken together, they provide the fabric that weaves together the disciplines of psychology, counselling and psychotherapy theory and practice. Together, they are bound by strict regulatory practices for clients as well as clinicians, who themselves are subject to the scrutiny of regulatory professional organisations. Micro-level systems of power are therefore supported and policed by macro-level organisational structures that rely upon local historical, cultural and subcultural conventions, according to Parker (1999b). Distinctions between the sane and the psychologically disturbed are therefore part of a complex infrastructure of what has been termed the ‘psy-complex’ (Rose, 1985). The effect of the psy-complex on individuals is that their social position can be determined by conventions of normality or abnormality. As a normalising practice, psychotherapy makes several basic assumptions concerning the treatment of ‘abnormality’: it seeks out an underlying cause of pathology; it locates that cause within individuals and their relationships; it purports to diagnose the cause within a psychological framework; and it provides a designated set of techniques for treating the pathology (Parker, 1999b). Parker concludes, “the issue of what constitutes the normal or the deviant, the functional or
dysfunctional is as much a sociocultural variable as a medico-psychological constant” (1999a: 21).

The recognition by some psychologists - particularly in the field of social psychology - that context-laden methods are employed in research for the evaluation of a knowable ‘reality’ has meant that psychology’s historic alliance with the approaches used in physical science is increasingly being questioned. As Shotter commented, “physical scientists don’t have evaluations placed upon them by their subject matter” (1992: 179). He argues from a social constructionist position that the lived experience of human beings cannot be taken in any way as basic or implicit and that it is the methods employed by psychology that often deny the ‘reality’ of people’s experiences. Scientific methods that observe behaviour and form from them generalised theories are regarded as subscribing to a monological paradigm (Shotter, 1995) which ignores, or at best diminishes, the primary point of human contact, that of conversation (Harre, 1992). The development of methods, which are jointly negotiated and linguistically formulated, adhere to a dialogical paradigm through which it is possible to discover foundations of human behaviour with a regard for the contextual background to life, according to Shotter (1995).

The Effects of Social Constructionism on Theory and Practice

This relatively recent movement within psychology has challenged the notion that one single, recognisable and reportable truth can be discerned through the examination of human ‘subjects’ (Harre, 1992; Potter, 1992; Shotter, 1992, 1995). The social constructionist approach has challenged the value of discriminating between types of cognitions - whether they are real or imagined - and it privileges social interactions, particularly those occurring in speech acts. The widespread debate concerning the conceptualisation of reality, which is currently resounding throughout the therapeutic and psychological communities, is strong evidence that the two-fold distinction between reality and fantasy does not provide an adequate basis for the understanding of people (Greenwood, 1989). Traditional approaches to psychotherapy have come under attack for the way in which individuals are regarded in isolation from their social environments (Cecchin, 1992; Gergen, 1991; Masson, 1990; McLeod, 1997) and pathologised according to socially constructed prescriptions of normative
behaviours (Gilman, 1985; Hepworth, 1999; Spence, 1987). As a radical rethink of positivistic approaches to psychological phenomenon gives way to post-modernist ideologies, so too the assumptions underlying the therapeutic encounter are challenged and social constructionist perspectives are becoming incorporated into both theory and practice.

Practitioners adopting a post-modern stance have acknowledged that the experiences of those marginalized by the dominant social order because of gender or racial prejudice can be so demeaned as to be considered pathologically fantastical (Chesler, 1987; Ussher, 1991). From the social constructionist viewpoint, foundations of thought and behaviour are perceived as arising from socially informed narratives about the self, reflected in language and speech. Narratives then, are situated within a social context and are seen as jointly negotiated enterprises that provide a sense of meaning and understanding to human encounters. The therapeutic encounter, as part of this linguistic system of meaning-making, provides an opportunity to facilitate a dialogic process of co-creating new narratives and alternative agencies (Lax, 1992). A dialogic paradigm is employed by social constructionists to show that language itself is a deeply influential determinant of perceptions (De Beauvoir, 1974; Sampson, 1993).

In order to overcome the inherently flawed assumptions of traditional Freudian analysis, new techniques based on post-modern, social constructionist philosophies have been emerging under the broad title of narrative therapies. These therapies tend to regard narratives, or stories, grounded in personal experience and social interactions as enabling the person to make sense of their world. In this way, narratives are regarded as neither real nor fantastical, but as fluid and changing. Stories told about the self are heard within the therapeutic encounter, where alternative narratives may also be presented. Narrative therapeutic concepts were originally incorporated into family systems therapy as a means of avoiding the pathologisation of a particular family member and as a way of regarding the family as part of an interactive social system (White and Epstein, 1990). Anderson (1991) further developed therapeutic strategies that placed clients within a wider social context by allowing families to observe what therapists within a ‘reflecting team’ had to say about them. Family
members were provided with the opportunity to participate in this process at a level on a par with that of the therapist. This technique has been adopted by conventional treatment centres like The Tavistock Clinic, in London, and indicates a move away from the clinician as knowing expert. Social constructionist perspectives are therefore having some effect upon the traditional approaches.

Clearly, current debates in psychology have arisen out of concern for the effects of theories and methodologies that privilege some accounts as real and some as fantasy, thus demonstrating that this two-fold distinction is not adequate to our understanding of the client. Although Freud imposed this distinction, it has undermined a more multi-dimensional understanding of people's lived experiences. The failure of psychological science to fully appreciate the complex nature of human phenomenon has been promulgated by research studies applying scientific methods which make presuppositions about the nature of reality and fantasy, regardless of the participants' own interpretations. The psy-complex has been structured around the scientist practitioner model and is a self-maintaining system that acts as an arbitrator of normality and abnormality. The context into which a particular 'patient' will be situated at any given time is a function of the scientist practitioner approach to counselling psychology, maintained by the psy-complex and based on local conventions and values. Social constructionists who regard dialogue as the primary point of human contact through which a sense of self is engendered, fostered and maintained are challenging this model. However, therapeutic contexts are primarily informed by dominant ideologies and these can be maintained and reproduced in therapeutic practice. Social constructionist ideology has begun to penetrate traditional therapy customs such that, the spectre of the neurotic patient struggling to grasp what the enlightened practitioner already knows about them, is no longer an adequate reflection of all psychotherapeutic practice.
References


**Therapeutic Practice Dossier**

This dossier contains information about the clinical work I have undertaken during the three years of my psychotherapeutic training. It includes a description of each of my clinical placements followed by a final clinical paper, which provides an account of my professional practice, including the integration of theory and research into my work.

Further details of client studies, process reports, placement logbooks and supervisors’ evaluation forms pertaining to this dossier are available to the examiners in a separate appendix. Due to the confidential nature of the material contained within this appendix, it is not available for public access.
First Year Placement 1: Primary Care
October 1999 – August 2000

This placement occurred in a primary care setting, which was attached to a local mental health trust. In this outpatient service there were three General Practitioners (GPs) making referrals to their internal counselling department, staffed by one psychoanalytic psychotherapist and myself. The surgery is a teaching practice attached to the local health authority and patients are therefore aware that training is an integrative part of the surgery’s structure. The counselling service was initially concerned with assessment of patients for brief therapy but onward referrals to other psychiatric services or for longer-term psychotherapies were also made. The main GP practice was located on the ground floor of the surgery with the counselling service being situated in a small upstairs room adjacent to the administration offices. This could make the service inaccessible to clients who were disabled or infirm. Patients referred for counselling had from one to three assessment sessions with a possibility of up to 12 more therapy sessions. The client group was largely middle class, coming from the surgery’s catchment area within an affluent suburb of a large city. Presenting problems included depression, anxiety, relationship difficulties, bereavement, alcohol dependency and health-related issues.

Other placement activities included a seminar on 'Primary Care Mental Health Services for Children: Development and Practice' at the local mental health trust hospital. There was also a full-day workshop on defence mechanisms and in particular projection and projective identification were discussed. Quarterly group supervision was also provided at the hospital.

First Year Placement 2: Eating Disorders Centre
October 1999 – August 2000

This placement concerned only one client who I began to see prior to starting the course, whilst I was on a placement working at a Centre for those diagnosed with Anorexia Nervosa, Bulimia Nervosa and Binge Eating disorders. Clients attending from the Centre were seen in the trainee’s homes for regularly weekly sessions. Although supervision was taken externally, the Centre provided a series of lectures on practitioner skills for eating disorders.
Second Year Placement: Psychotherapy Department

October 2000 – August 2001

This placement occurred in the Psychotherapy Department of a regional facility for both day and inpatients. It was housed in a separate building from the large General Hospital to which it is attached. The Head of the Department was a consultant psychiatrist who was also a psychoanalytic psychotherapist. In addition to having one full-time secretary on staff, there were eight other part-time psychotherapist staff members. They included a group therapist, a sex therapist, a couples therapist and five other general psychotherapists. There were two Counselling Psychologists in Training on this placement and the Senior Therapist provided supervision.

The Psychotherapy Department was housed in two separate areas. Part of it was on the same floor as the Psychiatric Outpatient Department and the other, larger part was adjacent to the Psychology Department, the Eating Disorders Service, the Electroconvulsive Therapy (ECT) Service and the Forensic Inpatient Ward. Following assessment, patients were offered either individual or group psychotherapy, if there was a place. Group therapy normally lasted for a period of two years. The Department also offered brief 16-session therapy and longer-term therapy; the exact duration was usually dependent on the needs of the patient. Patients mainly suffered from long-term illnesses, relationship problems and anxiety disorders. This was not normally their first experience of therapy.

There were many opportunities for becoming involved in a wide range of departmental activities, some of which were requirements of the placements and others were optional. Meetings included weekly departmental business and clinical meetings, at which I would often make client presentations. Group supervision was attended with other members of the department. There were also monthly meetings regarding the establishment of a Personality Disorders Service. I was a key member of this group and assisted in the preparation of a major proposal for this service. My participation included budget planning, planning of staff services and scheduling of a timetable of patient services. I was on the committee that assessed the administration of the CORE psychometric testing of patients. Several times I met with the Head of
Inpatient Services in order to gain an understanding of the facilities offered by the hospital. Also, I observed patients undergoing ECT.

**Third Year Placement: Co-ordinated Psychological Treatment Service & Community Mental Health Team**

**September 2001 – August 2002**

The setting for this placement was at a Co-ordinated Psychological Therapies Service for those with complex needs, both psychological and social. The service was housed on the second floor of a building on the hospital site of a large inner city but it was housed in a separate facility away from the main building. The Community Mental Health Team (CMHT) normally made referrals to this service and clients presented with problems including schizophrenia, obsessive-compulsive disorder, bipolar disorder and psychotic depression. The service mainly provided short-term individual Cognitive Behaviour Therapy (CBT) lasting from six to 20 sessions and, where appropriate, clients were offered the opportunity to attend an anxiety management group lasting seven sessions with a follow-up session four weeks later. Cognitive Analytic Therapy (CAT) was offered to some patients depending on whether or not their difficulties included repeated patterns of behaviour. The duration of CAT was 16 sessions, with one follow-up session a month later. Either the head of the department or the senior therapist provided supervision, both of whom were clinical psychologists.

A therapist attached to the CMHT provided supervision for group work and a specialist clinical psychologist provided supervision for CAT. Weekly departmental meetings were attended as part of the training and I presented both clinical material and theoretical papers at these meetings. Weekly lunchtime lectures were given at the main hospital site and subjects included, for example, the treatment of psychosis and assessment and referral procedures. There was also the opportunity to attend ward rounds at the inpatient unit.
On Learning to be an Ice-Skating Integrationist

"Between nature and nurture it looked quite grim. I'd been for some time, as I put it to myself, all right. But how could I be, genetically and psychologically, with parents like that? I came from a family of suicidal hysterics. I'd been suicidal and hysterical in my time, then taken stock and made a decision, or just grown out of it, but now I felt, as I walked back to the car, that for years I had been deluding myself into the notion that I had a choice. I felt myself to have been all along skating over the thinnest sliver of ice; believing that it was solid when it was only ever a brittle and probably diminishing floe... Thank you, Darwin; thank you, Freud."


Introduction

The intent of this paper is to provide an overview of my development as a counselling psychologist, particularly with respect to how I have integrated theory and research into my clinical work and approach to practice. I have begun with the above quotation as a reminder of how alienating our theories can sometimes be to the client in the room and how these theories therefore need to be applied sensitively and with regard to the effects they may have on the vulnerable people who seek our help. For many years the author Jenny Diski suffered from depression, having several episodes of inpatient care and sampling many of the various types of therapy on offer, both privately and within the NHS. For me, her lament, centring around the notion of choice, echoes that of many of my clients who feel hemmed into particular ways of being either by developmental process or biological determinants or sometimes by limited social opportunity. Clarkson eloquently states, "People and their problems come before any theories or techniques. The latter exist solely to serve the former, and any useful integration will always honour this position" (1998: 260).

To a large extent my therapeutic work has been about considering the idiosyncratic meaning of a client's current life situation or dilemma/s; investigating how they may have arrived at this particular place and at this particular time; speculating about what it might mean for the client to feel that choices are available to them; and finally, where appropriate, attempting to implement change or modifications to existing ways of being. I endeavour to do this whether working psychodynamically, cognitive behaviourally or dialogically. (The latter approach will be explained more fully later in this paper.) The particular approach of choice for each client depends upon their
personal aims and goals for therapy, the degree to which they demonstrate psychological-mindedness and the time constraints imposed either by the client’s or my own professional or personal circumstances or the resources available within the NHS. Because my work is informed by a diversity of theories, I would describe myself as an integrative practitioner. However, the work conducted in the consulting room with the client tends to be either directive or non-directive as I believe that movement from one position to the other may leave an already confused client feeling baffled about the very nature of therapy itself.

My view on the integration of the various theoretical positions is that sound clinical strategies should underpin client work and inform therapeutic interventions in a coherent and consistent manner. That is not to say that a client’s presenting problems should not be formulated from a number of different theoretical perspectives but that what is brought into therapy and presented to the client should be clearly planned and based upon an a priori hypothesis that reflects an intended stratagem for the attainment of psychotherapeutic goals. The integration of theories into practice without the articulation of such reasoned judgements could leave the client feeling bewildered and baffled by the process, confused by it and possibly even alienated, as in the case of Jenny Diski. She, perhaps mistakenly, believed that she was not at liberty to locate psychological theory according to her own ideological stance but that psychological theory located her within its own sedimented, irrepressible, culture.

For me, integration can be a deeply unsettling process, particularly when, as often happens, the client is unsure about what they would like to achieve in therapy. Sometimes it may seem that a cognitive approach would assist the client best by helping them to manage their distressing symptoms but a few sessions later, a focus on transference issues could appear to offer the client a deeper insight into their difficulties. Before ultimately deciding upon an approach, I therefore deliberate about how best to meet the client’s needs, and how to achieve, or approximate achieving, the client’s aims in a way that makes sense to the client based on their perception of their difficulties, and to me, based on my understanding of what the various approaches have to offer. Of course this integration is an ongoing process combining elements of further understanding of theoretical perspectives, an expanding base of research
interests, experience with clients who have a great diversity of problems and concerns, and personal development. In other words, as I learn so too do I integrate, but with caution. “Any good, competent and 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”, according to Clarkson, (1998: 260).

Lazarus posed the question “What treatment, by whom, is most effective for this individual, with those specific problems, and under which set of circumstances?” (1995: 38). Although he asserts that full theoretical integration is not possible, he does argue that to answer this crucial question requires of the therapist a knowledge of a number of models. By examining outcome studies, Roth and Fonagy (1996) have attempted to answer the question, What Works for Whom and their findings have sometimes helped to provide me with a rationale in the decision-making process about how and when to integrate. Where the presented research data positively resonates with client material it seems appropriate to inform therapeutic practice with studies based on clinical effectiveness and efficacy.

Clarkson (1998) has suggested that there are two pathways to the learning and assimilation of integration into practice. The first requires the trainee to begin to practice using a range of skills borrowed from a number of therapeutic approaches, essentially to take integrative therapy as a starting point for practice, and the second involves the trainee in the sequential practice of one core model prior to moving on and learning to practice in another. Prior to beginning this course, I spent some months using the former method in the treatment of those with eating disorders. I found this approach confusing because I lacked a coherent theoretical foundation on which to base my therapeutic interventions and I was therefore confused about my role in the treatment plan. Because of this experience I decided that whilst on this course I would seek placements that allowed for a concentrated effort on a single, core approach. My practice focussed on psychodynamic and cognitive behavioural approaches and it assimilated the basic principles of a humanistic approach. I will discuss the process of my development as an integrative practitioner including my
strengths and weaknesses, taking each core model learned in turn and illustrate this with case examples.

The Humanistic Approach

The central tenets of this approach lend themselves to incorporation into most psychotherapeutic models and encourage a number of practical skills that can usefully be employed by clinicians when working with a diverse range of theories and clients. The contributions of both Maslow (1943a, 1943b) and Rogers (1951, 1961) to the discipline of counselling psychology were seminal in providing a number of core conditions for the establishment of a positive therapeutic relationship. These include the congruence or authenticity of the therapist, the unconditional positive regard of the client as a person of worth and an empathic stance towards the client’s difficulties (Rogers, 1951). The specific skills of reflecting back to the client what they have said, checking that what the client has said has been understood, mirroring the client’s posture and tone of voice and noting and developing the client’s use of metaphor are encouraged as a means of facilitating a relationship that honours these core conditions. Obviously, these are basic skills that can inform any clinical work without requiring the practice of humanistic therapy. What sets the humanistic approach aside as a discrete therapeutic practice is its philosophical assertion that the person is an organismic self, seeking an essentially positive development and self-identity. Meams and Thorne claim that, “left to itself the organismic self knows what it needs for its enhancement both from its environment and from other people” (1988: 8). As my work in therapy often seems to be about sharing the client’s confusion concerning what is best for them, I do not share this view. So, although my work is informed by humanistic principles, I am not a humanistic practitioner.

Although during the initial stages of the course I was practicing psychodynamically, as a naïve practitioner it was helpful to maintain a stance of unconditional positive regard and empathy towards my clients. This was particularly useful in the case of Miss A¹ (see Client Study A, Appendix). Miss A was a middle-aged lesbian woman who had recently lost her business, her partner and the flat that they had shared.

¹ Clients’ details have been altered to protect their confidentiality and names used are pseudonyms.
together for several years. She had begun drinking heavily as a means of blotting out
the sense of loss that seemed to accompany her every waking moment. Establishing a
therapeutic alliance with Miss A was initially difficult because she had an
unapproachable demeanour and would change the subject when it came to the painful
issues of her life. However, by putting myself in her shoes and wondering where I
myself might be given her biographical past, as is suggested by the humanistic
philosophy, I was able to approach Miss A’s perspective with a deeper, more
compassionate understanding despite her communications to me to stay emotionally
distant.

It was clear that Miss A was an angry woman and that she vented her rage against
those with whom she had, or wished to have, close emotional attachments. Miss A
seemed to have become quite a callous person, having little regard for the feelings of
others and little empathy with those around her who might also be suffering. This was
particularly so with her partners’ young daughter who was nine years old. It was
tempting to regard Miss A as unworthy of psychological treatment because her
thinking was concretised and she often seemed oblivious to the pain she caused to
those around her. I had no doubt that she had been unkind to her step-child, perhaps
verging on the cruel in some respects, and that this probably contributed to the demise
of her relationship with her partner. However, throughout Miss A’s own childhood
there had been abuse of almost every description – physical, emotional, psychological
and sexual.

Miss A was not a stranger to loss, separation, rejection or abandonment as she had
experienced these in great measure throughout the whole of her somewhat brutalised
life. I found it difficult at first to have an empathic regard for Miss A but eventually I
found a point of contact when I realised that my wariness of her was perhaps a
reflection of her own fear of making intimate contact with me. By employing the
humanistic values of unconditional positive regard and the acceptance of the client as
a person of worth, I was able to attempt to approximate Miss A’s psychological state
within myself and therefore to understand and, importantly, to accept, why she might
appear to be so unpleasant and to lash out at those around her. This was a rare
experience for Miss A and she gradually responded by having an improved sense of
her own self worth, which was, in turn, eventually reflected in her attitude towards other people, including myself. I felt it was a strength that I could resist the temptation to judge Miss A harshly and instead to understand that her criticisms of me came from her own experience of being relentlessly criticised in childhood.

The Psychodynamic Approach

Both my first and second year placements were in settings that were strongly psychodynamically oriented, with both of my supervisors being psychoanalytic psychotherapists and initially I was probably most comfortable working within this paradigm because of my own experience of psychoanalytic psychotherapy. This approach takes a developmental perspective on psychological function and dysfunction, looking to early childhood experience to explain behavioural patterns of relating in the present. The client/therapist relationship is itself the subject of analysis as the client’s communications to the therapist are believed to reveal the unconscious psychical processes motivating the client’s behaviour. Transference and countertransference also feature as a focus of therapy as each contributes to an understanding of the therapeutic relationship and is analysed as a means of perceiving the client’s unconscious communications to the therapist. Although these processes (with the exception of countertransference) were developed and elaborated by Freud, Klein’s contribution to psychoanalysis is one of the most influential, informing the majority of contemporary formulations (Fonagy, 2001).

According to the Kleinian view, the first two years of life are foundational to later psychological functioning and this early stage of infantile anxiety must be analysed in order to confront and understand the unresolved aggressive drives that are responsible for prohibiting a person’s successful engagement in adult relationships. In other words, the way a mother attends her newborn infant is of paramount importance to later adult development and will influence all subsequent relationships. A problematic early relationship with mother will therefore leave the person with relationship deficits throughout their entire lives unless or until they have an analysis or experience a reparative relationship with someone else. Jenny Diski might have appropriately applied her metaphor of skating on thin ice to Melanie Klein’s view, and thanked her too, given the Kleinian perspective of psychological dysfunction. This theory is, of
course, deeply mother-blaming, taking little account of the person's other environmental circumstances or of the client's early relationships with other adults or siblings. Father seems to take on importance only if there has been some form of abuse experienced at his hands, and as the theory privileges mechanisms of sexual aggression, this sort of abuse is viewed as most deeply wounding to the child.

I was troubled by the focus of Kleinian psychotherapy on the infantile mother/child dyad and although I found supervision to be a difficult process, I highly valued my supervisor's sensitive application of this theory. Particularly in my first year of training, my supervisor was able to temper the more harsh focus of Kleinian therapy with an empathic understanding of the client's developmental processes. Although I felt challenged both professionally and personally by this work, my perseverance with the psychodynamic paradigm was recorded in my trainee evaluation form by my supervisor who said, "Debora's work was very good and in some aspects (capacity for empathy and ability to establish a therapeutic alliance) above the expectation for her level of training...I particularly would like to mention her capacity for criticism". It was during my training as a psychodynamic practitioner that I learned the usefulness of inviting criticism in order to grow as an experienced clinician. This of course had drawbacks too, in that persistent criticisms would sometimes contribute to my overwhelming sense of inexperience and lack of insight into the client's processes. In my worst moments I would be paralysed by indecision about what I should say to the client or whether or when I should make a particular intervention.

Kohut's (1977) contribution of self-psychology to the psychodynamic paradigm was especially influential in aiding my clinical ability to form a purposeful therapeutic relationship. This theory suggests that emotional and psychological needs can arise at any point during a person's lifetime and that once these needs are satisfied the person can then form fulfilling relationships with those around them. Empathic understanding of the client's world is a key feature of this approach, which, in contrast to Kleinian dictums, suggests that the fulfilment of the client's needs is required of the therapist rather than their frustration. The case of Miss D (see Process Report A, Appendix) illustrates an attempt to understand the client's expressed needs more clearly and exemplifies my struggle to address those needs within the therapeutic
encounter. Miss D was at a stage of transition in her life. She was about to complete her A level studies and then move away to attend university quite some distance from home. It seemed important that, not only should her needs be met as nearly as possible, but that she should also better understand her needs so that she could fulfil them with others in the future. In the submitted work, I concentrated on Miss D’s use of metaphors and I also endeavoured to understand how she perceived our relationship.

This is illustrated in the following extract from Process Report A. The P refers to me and the D refers to the client:

P14: Yeah, sure, but you you were saying last week when we were talking about the taping, um, that you wonder how I do it all. You wonder, you know, how I cope with the family, and cope with seeing clients, you know, and the course, and ...... I was wondering, you know, after you left, whether you think about how much room I have in my head for you with all of that other stuff going on in my life.

D14: ... We’ve talked about this before and I don’t think that you should be thinking about me all the time and I accept that you have, we have our allocated time and that’s fine .. because I can tell that you’re concentrating on what I’m saying because (laughs) you always remember everything and I don’t remember about myself and

P15: Mmm hnm

D15: it doesn’t feel like you’re more interested in someone else.

P16: Mmm hnm ..... Yes and I wonder, you know, if that’s quite gratifying to have someone pay attention to you for that period of time. But I’m wondering if it would also be nice to have it a bit more often and to know that perhaps I am thinking about you from time to time and I am wondering how the concert is going, how the play is going or whether you get on with your new art teacher.
D16: Yeah that would be nice but I don't want to get too attached to you because I
don't want to get too sad if we have to break off our meeting or, don't know, it's, it
would be nice if you were thinking, 'I wonder how the concert's going'.

Much of my underlying thinking was based on Kohutian ideas that some clients have
a need to experience a positive transference toward, or even to idealise, their therapist.
As this appeared to be the case with Miss D, it seemed helpful to probe the areas
where her parental and other relationships had been less than ideal. For me, the work
with Miss D represents a successful therapy because she has subsequently contacted
me from time to time with news of her progress, which appears mainly positive. Also,
she experienced a reduction in her binge eating symptoms and she has had no
subsequent contact with mental health services to my knowledge.

Although I was unaware of my therapist's particular psychotherapeutic genealogy for
the greater part of my time in analysis, I was surprised to learn that he had been
supervised by one of Kohut's own supervisees, who also worked with Kohut for many
years. This helps to explain why it appeared that I had naturally gravitated to Kohut's
work and why it had immediate appeal and meaning for me. Unlike several of my
associates who have had psychoanalytic psychotherapy or analysis, I did not feel
alienated by the process or painfully confronted by a 'blank screen'. My experience
was of warmth, compassion, empathy and a belief that I was a person of worth and,
perhaps most importantly, of promise. Kohut (1977) asserted that, ultimately, the
therapeutic alliance is the cornerstone of psychological repair and growth and it was
through my experience as a patient that I too came to understand the significance and
power of that relationship. Nonetheless, there are aspects of Kohut's self-psychology
that, for me, distract from the positive contribution he has made to theory. For
instance, he insists that the only pathogen of childhood conflict is parental failure
(Tolpin, 1980) and he therefore fails to account for other significant psychological
factors. However, in my view, no single psychological theory can offer a complete
explanatory framework for the understanding of human thought and behaviour.
The Cognitive Behavioural Approach

The transition from psychodynamic to cognitive behavioural (CBT) and cognitive analytic work (CAT), which I undertook in my final year of training, was a difficult one for me. For the most part, I liked the intensity and closeness of the relationship that built up over the long-term in my previous work and I was therefore reluctant to embark on a programme of brief interventional work that foreground psychoeducation and practical interventions. Therefore, I also undertook some longer-term schema-focused work. One of my schema-focused therapy clients, Mr N was a 30-year-old man with a recent diagnosis of bipolar disorder. A schema-focused approach was chosen for this client because he had previous experience of CBT, which he had found to be mostly unhelpful. He said that there had been a therapeutic agenda and that he was "incidental to it". Additionally he did not perceive his depression as having a significant developmental component, viewing his problems as being largely genetic. It seemed that Mr N, like Jenny Diski, felt that he too was skating on the thin ice of psychological theory, wanting help but feeling frustrated by the focus of both psychodynamic and cognitive behavioural approaches.

During our third assessment session the nature of his problem with CBT became apparent: he was terrified of challenging his automatic negative thoughts because this might cause him to begin to think optimistically, which potentially could trigger a manic episode, or so he thought. Employing a schema-focused approach appeared to work well with Mr N because it meant that we were able to speculate about the effects that his symptoms had on the way that he was living his life. He lived quietly, trying not to stimulate himself in any way, lest he should begin the upward spiral into manic depression. Although Mr N was initially unable to verbalize his feelings and emotions, he was able to use guided imagery to describe his experience of both manic and depressive episodes. Gradually, he became more comfortable with altering his perception of himself as a person who was paralysed by mental illness.

Mr N needed to work slowly and to feel contained and held during the therapeutic hour and the longer-term approach of schema-focused work therefore seemed an appropriate choice of therapeutic strategies. Whilst working with Mr N, I was also mindful of the social constructionist stance that his perceptions might be limited by
the culturally prescribed repertoires concerning psychological problems (see Harré and van Langenhove, 1999). I was therefore particular in addressing the specific meaning Mr N’s symptoms had for him. I asked him what it would mean never to experience the intense feelings of exhilaration that he had experienced before his diagnosis. Over time we came to talk about, not only the loss of the good emotions, but also the loss of the depressive feelings. It was as if we grieved that loss together in therapy before we went on to talk about the new ways of being that might be open to him. Because he seemed to need it, I shared my view of him with him, when I said, “I have positive feelings about you”. Mr N responded by saying that his experience of our time together had been positive and that he felt it had been a useful means of finding that “I’m not the bad person I used to think I was”.

The Dialogic Unconscious

The proposition that most closely approximates my own ideological stance and experiential background is that of the dialogic unconscious (Billig, 1997a, 1997b, 1999, 2001). Because I have written quite extensively of my interest in the dialogic unconscious elsewhere in this Portfolio (see ‘The Dialogic Unconscious: The Missing Link or a Contradiction in Terms’, p.32 and my research paper, ‘How Rude Can You Get? The Dialogic Unconscious in Therapy’, p.164), I will only briefly summarise this concept. The dialogic unconscious combines the Freudian notion of repression with the social constructionist perspective that conventional knowledge is based upon society’s taken-for-granted assumptions; that ways of understanding are historically and culturally relative; that ‘truth’ is constructed in social process and, that social actions are conjoined with systems of knowledge (Burr, 2000). Billig (1997a, 1997b, 1999, 2001) uses the notion of repression to explain language as having repressive as well as expressive functions. The benefit of this approach is not only that I feel epistemologically coherent in its use but also that it explains deficits in the theories of psychoanalysis and social constructionism. It articulates the ways in which speakers are able to suppress certain topics of conversation without being aware that they are doing so. These repressions occur in conversation with other people and internally, as part of a person’s inner dialogue. This is useful therapeutically because it provides insight into the nature of the problems clients encounter in the self-identities they construct in both internal and external conversations.
As an example, after about a month in therapy, Miss M consistently came late to her sessions. It was my sense that she was angry that I had not provided her with any concrete ‘answers’ to her problems and that she was essentially voting with her feet. When I suggested to her that she might be angry with me, she accepted that the therapy fell short of her expectations but she denied that she would act on these feelings. Miss M always constructed what seemed to be reasonable reasons for her lateness and my interpretations aroused a great deal of anxiety in her. The depth of her anxiety and her concern that I should be convinced that her lateness was unavoidable confirmed my view that she was both angry and unaware of her anger. It felt as if I was working very hard with this client, only to have my efforts rebuffed and this was often a frustrating and sometimes an annoying process. I experienced Miss M's politeness as exaggerated and insincere. Miss M had been adopted as an infant and she seemed to have spent the greater part of her life trying to be polite and helpful to her parents as a means of showing gratitude for her adoption. She appeared to have constructed an identity that prohibited any experience of herself as rude or impolite. She was always deeply apologetic about her lateness.

By being attuned to the difficulty that Miss M had in verbally expressing and presenting herself as someone who could only be compliant, I was better able to appreciate why she was depressed. She felt that she was someone who tried very hard to please other people but who was unappreciated by those around her. The dialogic unconscious provided a framework for the conceptualisation of Miss M’s difficulties as arising from dialogic repression and I was able to formulate a treatment plan that focused on the rituals of politeness that informed her everyday speech acts. I asked her what it would be like not to apologise for being late. She said that I might not like her and that I might even stop seeing her. I asked how she was so sure that her assumptions were right and also that it was inevitable that we would stop meeting even if she always did everything that I considered to be ‘right’.

After some months in therapy she acknowledged what she had been unable to say previously, perhaps even to herself - that she felt that she had greatly disappointed her adoptive family and that they had wished for a “trophy child” to make them look good. She said that she had spent the entire of her childhood attempting to
compensate for this without acknowledging that she was doing so. Miss M left therapy at a time of crisis – her father had become terminally ill - and it was difficult to get a sense of her progress. Although she reported “feeling better” I was unsure as to whether or not she perceived me in the same way that she had experienced her family – superficially positive, but all the same disappointed in her. However, I was equally unconvinced that another theoretical approach would have reaped greater rewards.

Perhaps the greatest problem with working with the dialogic unconscious is that it is not widely understood or employed in therapeutic practice and therefore obtaining supervision that corresponds to its central tenets is not possible. Hence, I have no means of checking or evaluating my work with the dialogic unconscious except through my sense of attunement with the client or through informal dialogues with social constructionist practitioners or through the use of follow-up clinical measures like the Clinical Outcomes in Routine Evaluation System (CORE, 1998). These measures are somewhat unsatisfactory because, although they may indicate that a client’s condition is improved, they fail to capture the specific agents of change. My utilisation of the dialogic unconscious is therefore a work in progress that could be enhanced by the input of other professionals.

Conclusion
My development as an integrative practitioner has been cautious. I have attempted to learn to practice first from a psychodynamic perspective and then from a cognitive behavioural perspective. I have also been deeply influenced by the social constructionist view that many versions or accounts might abound concerning a single phenomenon. Theories should act as a structure to support the client. Like a solid floe of ice, they may not be entirely without ruts or catches or cracks but they should help to prevent the client from slipping helplessly into the black and treacherous waters of anxiety, depression or suffering, below. While I continue my development as a counselling psychologist, I hope to be able to generate, within myself, new understandings of what it means to make the journey into the Antarctica of the client’s distress and to help them face the challenge and risk of gliding uncertainly across the therapeutic ice.
References


Research Dossier

Three research reports are included within this dossier, one from each year of the PsychD programme. The first two papers are linked by their common interest in eating disorders and by their critical stance to contemporary treatment models. All of these papers are epistemologically coherent in their adoption of a social constructionist ideology. However, the final paper in this collection adapts the social constructionist approach to incorporate the psychoanalytic concept of repression.

The first paper reviews the literature in the area of eating disorders and, taking an historical perspective, it spans a time frame beginning with the medieval saints and moving through to the present day. Subheadings have been altered from the original submission in order to comply with suggestions made by Markers. For the same reason, I have taken a more straightforward approach in my description of Hilda Bruch's psychoanalytic theory. My original paper also included a quote from Ian Parker regarding the considerable influence of Lacan on contemporary psychotherapy practices and, because it seemed an overstatement, this has now been omitted.

Therapist's constructions of anorexia nervosa and their own roles in its treatment are investigated in the dossier's second paper. This work examines the texts of individual therapists in order to take a critical stance on clinical practice. Markers were concerned that the criticisms made in this paper might be open to the misinterpretation that I was being judgemental and devaluing of those individuals who participated in the research. I was as eager to avoid that misconception as were the markers and I have therefore rewritten the Personal Overview section of the paper. It is made clear in this section that the detailed study of texts required by the research methodology is not undertaken as a means of attacking specific therapists but it acts as a device for the underpinning of philosophical and theoretical assertions.

The final paper on the dialogic unconscious represents an attempt to identify whether or how a novel theoretical concept, requiring the modification of both psychoanalytic and social constructionist perspectives, might be applied to clinical therapeutic practice. Because of its innovative stance, markers were somewhat unsure of how to
evaluate this paper and, in the original submission, suggestions as to how this might be done were inadequately addressed. This area of the paper has been elaborated, and hence improved, by this inclusion. Many other aspects of the research have also been substantially altered. The main criticism of the work, as previously submitted, concerned some seemingly reality-based readings of the text, which are impermissible in discourse analysis. The analysis has been honed and sharpened in order to make the social constructionist epistemology underlying the work more readily apparent. However, any incorporation of a psychoanalytic concept into this ideological framework seems likely to unsettle some advocates of the discipline. Vivien Burr (1995) has suggested that social constructionists are a diverse group who can be identified by their ‘family resemblance’ to one another. This paper introduces the dialogic unconscious as a challenging newcomer to the traditions of this family.

References
From Fasting Virgins to Faulty Mothers: The Social and Historical Construction of and Therapeutic Approaches to Eating Disorders

This article examines the social and historical foundations of eating disorders and considers their implications for theory and psychotherapeutic treatment. Selected historical literature concerning constructions of self-starvation from the Middle Ages through to the first recorded diagnosis of anorexia nervosa in the 18th century is discussed. Comparisons are drawn between the social conditions that informed early practices of self-starvation among holy women and the social conditions that inform contemporary conceptualisations of eating disorders. The effect of dominant ideologies, especially that of mother blame, on the delivery of treatment for eating problems, is considered. 'Feminist' psychoanalytic approaches to eating disorders are examined and criticised for their reliance on concepts and practices that oppress and subjugate women. A social constructionist, narrative approach to therapy is considered to be significantly less problematic for feminist therapeutic practitioners working with women with eating disorders.
From Fasting Virgins to Faulty Mothers: The Social and Historical Construction of and Therapeutic Approaches to Eating Disorders

Since the 1960s there has been increasing psychiatric, psychological and public interest in eating problems and the factors that may be responsible for initiating and sustaining them. At first, attention was directed towards the increased incidence of anorexia nervosa (AN) which has the highest mortality rate of any formally categorised psychiatric condition, with deaths occurring in 15-20 per cent of the affected population (Crisp et al., 1992; Sacker and Zimmer 1987). In the 1980s, eating patterns which incorporated a binge/purge cycle were identified separately from AN as bulimia nervosa (BN) and they too became the subject of much media and medical scrutiny. This cultural fascination and preoccupation with eating disorders (Malson, 1997) has been accompanied by an ever-expanding market of private and public professional facilities for both in-patient and outpatient treatment. As 90-95 per cent of AN sufferers and a similar percentage of those diagnosed with BN are women, explanations that account for the gender-specific nature of these conditions are of particular concern to feminist scholars and therapeutic practitioners.

Criteria for a diagnosis of AN have been defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) as a refusal to maintain body weight over a minimally normal weight for age and height; an intense fear of gaining weight or becoming fat, even though underweight; undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight; and in women, absence of at least three consecutive menstrual cycles. Two subtypes of AN are defined in DSM-IV as being bulimic, in which recurrent episodes of binge eating take place, and nonbulimic, in which these episodes are absent.

Diagnostic criteria for BN are more complex. It is defined in DSM-IV as recurrent episodes of binge eating which are characterised by both eating in a discrete period of time an amount of food that is definitely larger than most people would eat in a similar period of time and a sense of a lack of control over eating during the episode. An average of two binge-eating episodes per week for at least three months together with
a self-evaluation that is unduly influenced by body shape and weight are required. These disturbances must not occur exclusively during episodes of AN and there are two types. Individuals exhibiting the purging type engage in self-induced vomiting or laxative or diuretic use and those exhibiting the non-purging type use strict dieting, fasting or vigorous exercise but do not engage in purging.

Moving beyond the standard medical and psychiatric understandings of AN and BN, these conditions have been examined in critical and political ways by feminist scholars. As the female body has been identified as a prime site of women’s oppression (Bordo, 1993; Coward, 1987; Lawrence, 1987; Ussher, 1989), the social representation and construction of the female body has been of interest to feminists concerned with eating disorders. Implicit in feminist theory is that female biology has historically been and continues to be problematised within the culture of medical science (Goudsmit, 1994; Goudsmit and Gadd, 1991). The historical analysis of eating disorders by Bell (1985), Hepworth (1999) and others - beginning with the self-starvation of holy women in medieval times through to the examination of AN and BN in more recent times by Bordo (1993), Malson (1998) and colleagues - has illustrated the effects that cultural assumptions can have on women’s suffering. That medieval fasting practices are directly connected with modern day expressions of self-starvation is a widely drawn conclusion that invites further analysis into the social conditions that may be relevant to the aetiology of eating disorders in the past and currently. In both cases, there are a number of interrelated cultural factors that appear to be connected with an increase in the disturbed eating patterns of women. In order to specify and analyse them, feminist writers have often adopted a social constructionist approach, informed by the work of Michel Foucault. His work suggested that dominant ideas are rooted in the cultural maintenance of power relations. Foucault (1983) was interested in how individual people constituted forms of power and how they were, conversely, constituted by power relationships. In delineating the relationship between the socio-symbolic meaning of women’s disordered eating practices and the relevance this has had in supporting patriarchal authority, feminists have identified how women with eating problems are enmeshed within a self-regulating power structure.
Crucially, the dominant ideologies of any particular historical period have been shown to be maintained and reproduced in theories of the mind and body and, in more recent times, in the therapeutic practices that evolve from them (Parker, 1999; Parker et al., 1995). It is the aim of social constructionism to redefine constructs like ‘the mind’ in order to uncover the cultural foundations that inform the practices of psychology and psychotherapy. The present article broadly aims to explore the cultural foundations of eating disorders and evaluate how the resultant narrative might contribute to a reformulation of theory and treatment in relation to these conditions. Firstly, a brief discussion of selected literature concerning historic constructions of self-starvation from the Middle Ages through to the first ever diagnosis of AN will be presented. Comparisons will then be made between the social conditions that led to that diagnosis and the conditions implicated in more modern presentations of eating disorders. This will include an analysis of the effects that have followed generally from the works of Sigmund Freud and John Bowlby and, more specifically, from the practices of Hilda Bruch.

An examination of the subsequent application of psychoanalytic principles in the treatment of eating disorders by two feminist practitioners, Susie Orbach and Karin Bell, will follow. Finally, the contribution of social constructionist analysis to the reconceptualisation of therapeutic conventions will be examined with particular regard to the treatment of women with eating disorders. A connection will therefore be made between historic practices and assumptions concerning women’s eating behaviours and psychologists’ understandings of eating disorders as individual pathologies. To demystify eating disorders by exposing their historical relationship with dominant power structures may encourage the psychological reconceptualisation of what are considered to be amongst the most serious ‘psychopathologies’ of our time. For Malson (1998), an historical analysis is essential to psychological inquiry and practice generally as it can provide the theoretical underpinnings for the development of new or at least better informed strategies for treatment.

**Constructing Gendered Eating Patterns: From God to Gull**

Bell (1985), Garrett (1998), Hepworth (1999) and others have highlighted how, as long ago as the 12th and 13th centuries, self-starvation was socially constructed as a
particularly desirable and aspirational state for holy women. Those who could endure and continue to exist through long periods of time with little or no nourishment were highly revered and were regularly rewarded with consecration into sainthood subsequent to their often premature deaths. According to Bell (1985), this self-starvation was frequently accompanied by bulimic practices in which nuns would gorge themselves on large amounts of food which would then be expelled by self-induced vomiting. As the fasting customs of these holy women so closely resemble the dieting regimes of contemporary AN sufferers, some diagnosticians have made retrospective diagnoses of AN (Bliss and Branch, 1960; Lacy, 1982; Rampling, 1985). At the time, it was believed that the ability to self-starve was sustained by profound religious insight. Contemporary researchers have also made associations between the degree of weight loss in AN sufferers today and the depth of their religious beliefs. For example, Joughin et al. (1992) suggested that religious asceticism can be invoked to justify, supplement or replace the defense of weight loss in AN.

Bell (1985) has asserted that, regardless of the specific historical period in which food refusal is expressed, the body becomes the *tabula rasa* on which women attempt to compose a meaningful female identity against the backdrop of a male dominated and regulated society. He has deconstructed the meaning of self-starvation for women then and now so that eating practices can be understood in the contexts from which they have emerged. However, his ideas rely heavily on the notion that self-starvation was an elective strategy employed as a means of protest against patriarchal religious practices. This seems unlikely given that holy women embodied the social values of their time and only rarely attempted any radical church reforms.

The perspectives adopted by Hepworth (1999) and Malson (1998) have more apparent merit in that they examine past and current discourses of femininity - and masculinity - in order to expose the cultural assumptions on which those discourses were based. According to these writers, during medieval times, women’s opportunity for renunciating material goods was confined to food, in contrast to men who were able to exchange their worldly possessions for the promise of eternal salvation. Saint Christina the Astonishing wrote that she ‘gave up food because she had nothing else to
give up for Christ’ (cited in Malson, 1998: 50). The male position of the time was an elevated one in which religious and economic power over women was maintained at both local and institutional levels. Foucault (1988) has described a technology of the self in which the practice of subjugating the self occurs through disciplines of the mind, body, spirit, behaviour and thought. The disciplines of self-starvation, which characterised the behaviour of the saints, can be interpreted as a technology of the self in which the power of the church was maintained by the self-subjugation of holy women. The technology of the self coexists, according to Foucault (1988), with the technology of power in which people are subjugated through techniques which monitor and control many elements of their lives by making continuous comparative references to the standards of others.

Medieval women who had little or no wealth were judged according to a male standard of self-sacrifice, which constituted as positive their ability to deny themselves even the basic requirements for existence. The male model of behaviour was the yardstick by which women were then judged as being different; Hepworth (1999) and Malson (1998) have suggested that women’s comparative differences were so culturally reified as to form the fabric of social thinking. Hepworth (1999) has convincingly argued that these early constructions of ‘good’ holy women provided the preconditions for later polarised constructions of women as evil heretics. It seems plausible that dead and starving women, in the form of saints and the religiously compliant, helped to maintain rather than threaten the prevailing social order of male hegemony.

As keeper of the social order, the religious establishment was the ultimate arbiter of normative and non-normative behaviour, good and evil, sanity and insanity. During the 15th and 16th centuries, the social construction of many women as deviant, devil-worshipping sorceresses culminated in their torture, burning and drowning in witch-hunts. Ehrenreich and English (1979) believed that women - particularly peasant women - were becoming increasingly skilled as lay healers and midwives at this time and that this posed a challenge to the knowledge and power bases of the prevailing Christian authorities. When invoking the help of God failed to overcome pain and suffering, the herbal medications supplied by peasant woman were sought. As
women's healing powers became more and more refined, so too did their persecution by the church. Hepworth (1999: 17) has suggested that the medieval practice of persecuting women as witches became ‘an organised, large scale system of governing women and “deviants”’. She proposed that this is directly relevant to the ways in which women were later perceived as having a corporeality that was out of control and which culminated in sexual and eating difficulties (see Ogden, 1997, on the theme of control in eating disorders).

Both Hepworth (1999) and Malson (1998) have created a link between early constructions of femininity and later expressions of women’s ‘madness’, including AN and BN, through the notion of hysteria. Witchcraft was believed to be caused by hysteria, a word that was coined from a Greek word meaning ‘womb’. Thus the female reproductive system was targeted as the site of female instability, wickedness and insanity. As Hepworth (1999: 18) observed, ‘Hysteria constituted a major attack on women that was aimed at that which was most specific to women and symbolic of feminine power: the womb’. This idea proved most persistent, so that even in 1819, the French physician, Jean-Baptiste Louyer-Villarmay, could still declare that ‘A man cannot be hysterical. He has no uterus’ (cited in Showalter, 1997: 64). There is much evidence to support the view that early discourses privileged men’s reproductive powers and oppressed women by pathologising theirs (Ehrenreich and English, 1979; Martin, 1989; Showalter, 1985).

King’s (1983) analysis of early Roman society has demonstrated that women were defined according to their reproductive capacities from that time. Clothing was used to denote the reproductive stage of life a woman had entered and separate living accommodation was provided for those in the premenarche, menarche and post-childbirth stages. Until a woman had borne a child, she was not permitted to enter society fully and those who never experienced menarche or childbirth were considered to be lunatics and lived separately in compounds for the insane. This research suggests that a system of governing and regulating women that relied on ideas concerning their reproductive systems existed much earlier than Hepworth (1999) has acknowledged. Moreover, it may also have been the case that the increasing deification of female saints amongst the lay population in medieval times presented a threat to the
hierarchical practices of the male-dominated Christian church and that this contributed to the development of a polarised view of women as being demonic.

More generally, the premise that women’s biological functioning is intimately connected to their level of psychological (im)balance was a strongly-held belief that informed much of the later medical literature from the 17th and 18th centuries. For example, according to Martin (1989), at that time specific states and traits such as poor judgement, lack of co-ordination, dizziness, fainting, mood swings, depression and anxiety were constructed as being particularly feminine traits that arose out of a fragile and vulnerable reproductive system. This link is still observed in ‘raging hormones’ theories, which aim to explain pre-menstrual syndrome and postnatal depression (George and Sandler, 1982; Golub, 1992; Mauthner, 1993; Romito, 1990; Walker, 1997).

Using the Foucauldian rationale of the technology of the self, Bordo (1993) asserted that individuals would self-orient to prevailing culture practices. She quoted Mary Wollstonecraft’s 1792, and now classic, articulation of women’s surrender to preconditioning: ‘Taught from their infancy that beauty is woman’s sceptre, the mind shapes itself to the body, and, roaming round its gilt cage, only seeks to adorn its prison’ (Bordo, 1993: 18). During the early part of the 18th century, the malaise that women experienced as a result of their cultural oppression was associated with medical and psychiatric conditions that constructed them as incapable and susceptible to fainting spells, inertia and lack of motivation. This tendency to pathologise women’s behaviour led to the first ever diagnosis of anorexia nervosa, according to Hepworth (1999). She has suggested that when medical causes for female dysfunctions like self-starvation were not readily apparent, physicians sought explanations in the developing ‘science’ of psychiatry.

In 1874, William Gull reviewed the first case of what he termed ‘anorexia nervosa’, which he believed was characterised by loss of appetite, although it is rarely the case that those with anorexia stop feeling hungry. At the time and despite having seen only two cases of food refusal, Gull described AN as afflicting mostly young middle class women and this characterisation of the condition is still evident in the medical
literature today. He also drew upon notions from the medical literature which problematised women’s personalities and morality when he suggested that priests and moral advisors should attend afflicted women in order to promote moral rectitude. By depicting AN in this way, Gull promoted a view of femininity that conformed to stereotypical notions of women’s conflictual and irrational natures and, probably because this view resonated with popular medical opinion, he was able to convince his colleagues of his diagnostic and treatment acumen in the area. At the same time, he was able to elevate his position and influence within the medical community.

According to Showalter (1997: 17), ‘a doctor or other authority figure must first define, name and publicize the disorder and then attract patients into its community’. She also suggested that their efforts are rewarded, as they become known as leading, distinguished and renowned experts in their areas of medicine or psychiatry. At the same time as Gull was promoting his ideas about AN, a French counterpart was also theorising about cases of self-starvation. The medical literature records a debate between the two physicians concerning who first discovered and documented AN and Hepworth (1999) believed that the two were locked in a battle to become known as one of the 19th century’s ‘Great Men of Science’. By providing an historical analysis of religious and medical discourses and an analysis of the discourses of femininity and masculinity which may have significantly informed present-day conceptualisations of AN and BN, feminists - and in particular Hepworth (1999) and Showalter (1985, 1997) - have provided greater transparency to psychological understanding of the aetiologies of these conditions.

Although these historical and social deconstructions may not provide ready solutions to eating problems, they have helped to illustrate the effect of religious practices on eating behaviours and their connection with the effects of medical practices on the psychological evaluations of women with eating problems. The effect of the construction of AN as an illness which afflicted mainly adolescent and young women who were exhibiting hysterical symptoms and who were therefore seen to be mentally unstable was to confirm an ideology of femininity as weak, child-like and dependant upon male authority and control. Defining anorexia nervosa in such a way also
authenticated an ideology of masculinity as insightful and understanding of the female condition.

Eating Disorders as Gendered Psychopathology: The Contribution of Freud and Bruch

Like Gull, the culture into which Sigmund Freud emerged - and which he was later to dominate - was one in which the notion of hysteria had already been assimilated and was being reproduced by its populace. Also like Gull, the way in which Freud interpreted women's behaviour generally was to have an enduring effect on the ways in which women's eating behaviours would be pathologised and treated. As the explanations Freud (1955) offered for hysteria and neurosis were based on theories of infantile sexuality and psychosexual development, they were shocking to the society of the time. However, it was probably because they emerged from commonly accepted assumptions regarding women's inherent personality defects and men's superior moral and psychological functioning that Freudian principles were palatable enough to be sanctioned by the scientific community and consequently to gain general social acceptance. When Freud (1953) proposed that adult personality and behaviour was to a large extent contingent upon early infantile sexual experience and development, he carved out separate psychosexual pathways for men and women. Men and boys were defined by the presence of the penis and women and girls were defined in relation to their lack of a male sexual organ, in terms of 'phallic lack'. Freud (1953) argued that successful resolution of the Oedipal complex, which was said to occur at about the age of three, was crucial to a boy's healthy adult development. For girls, Freud (1953) offered a theory that situated and fixed gender identity within the notion of 'penis envy'. Women, according to Freud, were inferior to men, vain, lacking in superego development and thus deficient in moral reasoning. They had, he said, a natural orientation to heterosexuality in their experience of the vaginal as opposed to the clitoral orgasm and ultimately they only partially reconciled their inherent sexual inferiority in the production of a child, preferably male. In this way, Freud offered a plausible explanation as to the underlying mechanisms and psychology of social norms, including male hegemony, by describing it as the outcome of normal psychosexual development.
Despite many criticisms from many quarters, Freudian theory has had a deeply influential effect on the theoretical assumptions and treatment approaches of both mainstream and feminist practitioners with an interest in AN and BN. Critics of Freud have suggested that he was the product of a middle class, Victorian, sexually repressed society and that the prevailing patriarchy of the time is reflected in his doctrines (Leahey, 1997; Lerner, 1986a; Masson, 1990; Ramas, 1983). In 1903, seven years after proposing that the sexual violation that some women experienced could lead to physical and behavioural problems, Freud withdrew his seduction theory in favour of one which labelled reports of abuse as fantasy. The effect of this shift was that individual dysfunction was reinstated as being predominant to psychopathology. The effect of that U-turn is nowhere more present than in the treatment of eating disorders, which often relies on psychoanalytic theory in practice.

When, in the 1960s, greater popular awareness of AN developed and the condition was represented as the affliction of the modern generation of adolescent girls and young women, the treatment of choice was Freudian psychoanalysis. Together, the core components of free association, an open and unconstrained dialogue generated by the patient, the analyst’s interpretation based on this dialogue and the patient’s emotional response to the analyst (called ‘transference’) are presumed to aid the discovery of the unconscious influences which motivate the behaviour of the individual (Dryden, 1996). Despite the common acknowledgement that cultural factors are heavily implicated in the aetiology of eating disorders, the psychoanalytic principle of seeking causation in individual pathology is usually relied upon in treatment.

Hilda Bruch, the first of the more recent psychoanalytic practitioners to publicise her interest in eating disorders, embodied the qualities that Showalter (1997) regarded as essential to the creation of modern day analogies of hysteria. As Professor of Psychiatry at a medical school in Texas, she was already an established figure in the psychiatric community and her theory of AN resonated with the female adolescent population for whom the condition was believed to be a problem. For her efforts she became known as ‘Lady Anorexia’. Populist images of adolescent girls portray them as struggling to fulfil a great many conflicting cultural expectations including that of
achieving success as an independent woman with a promising career ahead whilst also remaining tied to home and family commitments. Adolescent girls are depicted as having romantic ideations, increasing sexual awareness and a need to establish self-identity within a family that misunderstands them, and Bruch incorporated these elements of perceived adolescent development into her theory of AN.

Comparisons have been made between Bruch’s (1978) characterisation of anorexic girls and the personalities and circumstances of young women created within romantic fiction written for an adolescent female market. A parallel between the inner world of the anorexic as described by Bruch (1978) and the inner world of the heroines of some romantic novels has been drawn by Brumberg (1988). She described the ‘plots’ as having a notable similarity with the characters in both being attractive, intelligent, high achievers who are misunderstood by their families, particularly their mothers. Their ability to achieve success in dieting is taken too far as a result of the complications of adolescence and, in both portrayals, the girl becomes afflicted with AN. The publicity surrounding the disordered eating patterns of possible role models for adolescent girls - such as the late Diana, Princess of Wales and Calista Flockhart - reinforces an idealised and fanciful perspective of AN and BN. Showalter (1997) has suggested that the romanticising of these conditions in popular fiction and in Bruch’s theory, together with their connection with highly successful and prosperous media personalities provides an alluring image which seduces the adolescent girl into identification with them.

Bruch (1985) reported that, in the 1980s, patients ‘tried out’ anorexia after having watched a TV programme or, rather bizarrely, after assembling a science project. Although she acknowledged the effect of publicity on the conditions, she attributed the growing incidence of eating disorders to unspecified changes in the clinical and psychological ‘picture’. Her identification of the etiological factors implicated in what she termed ‘primary anorexia nervosa’ is, however, quite clear. The theory of AN with which Bruch was first acquainted when she began her practice in the 1930s was based on Freud’s theory of psychosexual development. For the anorexic, eating was considered to be symbolic of impregnation and fatness as symbolic of pregnancy. Rahman et al. (1939) proposed that the condition served as a protection against the
assumption of normal sexual relationships and Waller et al. (1940) provided an elaborate account of the condition in terms of fantasies of oral impregnation and of rejecting the idea of having a child in the abdomen. Classic psychodynamic interpretations of AN considered the disorder to be a defence against unacceptable sexual impulses and this view continued to be predominant until Bruch reinterpreted the symptomology.

Whereas psychoanalysis traditionally considered female psychosexual development to be inherently deficient, Bruch (1974) suggested that poor mothering could account for AN. She described a process wherein the infantile mother/daughter relationship was characterised by ‘absence of regular and consistently appropriate responses to the infant’s needs, particularly to the need for food’ (Bruch, 1985: 13). This, she argued, deprives the growing child of the basic requirements for the healthy development of body identification and later emotional self-expression. The fundamental problem, according to Bruch (1978), is not one of disturbed eating function but is one which centres around the mother’s difficulties in responding to her child’s needs, effectively leaving the adolescent with no core personality of her own. Although this theory departs from earlier psychoanalytic views, it maintains the thread of female hysteria as causative of psychological dysfunction and in that sense it is a case of history repeating itself. Once again, the prevailing cultural assumptions concerning women’s inferiority and their need to be kept under strict social control for their own edification were incorporated into a theory offering psychological restoration.

Another theme that was repeated from the analysis of the fasting holy virgins of the Middle Ages and appears to have influenced Bruch’s (1985) views is that of the idolisation of the self-starving. There is a substantial corpus of literature stemming from Bruch’s first clinical experience of eating disorders, which suggests that thin women embody the most desirable of feminine qualities. A longitudinal study by Garner et al. (1980) showed a gradual but definite trend towards increasing thinness in women as a cultural ideal from the early 1960s and, since then, the media have continued to promote and reinforce increasingly skeletal images of women (Bordo, 1993; Hamilton and Waller, 1993; Lawrence 1987). Bruch (1985) also appeared to elevate the status of women who display the resolve and control required to self-
starve. She perceived those with AN as being in a prestigious position by comparison with other women who aspire to such determined self-discipline. Of bulimics she said, ‘They make an exhibitionistic display of their lack of control or discipline, in contrast to the adherence to discipline of the true anorexics...Though relatively uninvolved, they expect to share in the prestige of anorexia nervosa’ (Bruch, 1985: 12).

The theory Bruch offered also coincided with the social view that was emerging during her first encounters with eating disorders in the 1950s that working mothers were responsible for their children’s psychopathologies. It has been argued that, in post-war Britain, a political agenda existed which sought to return women to the realm of the domestic and restrict the industrial world to the work of men (Birns, 1999; Franzblau, 1999). John Bowlby was commissioned by the World Health Organisation in the early 1950s to study the effect on children of mothers being in the workplace rather than in the home and he concluded that the experience of maternal deprivation caused such serious and lasting trauma to the child that it could result in psychosis and criminality (Bowlby, 1969). Social and political pressures on women to remain in the home in order to raise their children became commonplace when Bowlby recommended that financial resources be directed away from daycare facilities and toward providing home care services. Bowlby used psychoanalytic principles to inform his research and he based his deductions on the Freudian assumption that the infant’s relationship with its mother established the prototype for all later relationships. Lerner (1986b) has contended that, as a result, contemporary women have been left the legacy of a mother-blaming society in which their every action is scrutinised and found to be destructive or damaging to their children. The theme of mother blame was central to Bruch’s argument concerning the causes of AN. She suggested that the aetiology of eating disorders is only marginally affected by cultural pressures to attain an unrealistically low body weight but that other social forces more actively promote eating problems. Her view implied that working mothers are not sufficiently placed to provide for their daughters’ psychological and emotional needs and that they are also inadequate as role models. Finally, she concluded of disordered eating patterns that their ‘frequency during the past 20 years appears to be related to psycho-sociological factors, chiefly to those of the women’s movement’ (Bruch, 1985: 18). So, in this analysis, working mothers are responsible for their daughters’
psychopathologies because only they can appropriately attend to their needs - but it is feminism that has corrupted motherhood.

Bruch’s (1985) contention that the women’s movement has destabilised the domestic welfare of children raises some interesting questions concerning her own position as a highly successful career woman and mother. Was she suggesting that other women are not as capable as she was in balancing the requirements of home and job or did she regard herself as one who, by virtue of her elevated status amongst a largely male professional population, was positioned outside her own proscriptions? There are other problems associated with Bruch’s (1974, 1978) theory. It fails to account for why the overwhelming majority of those affected by eating disorders are female and it offers no similar developmental pathology for boys whose mothers fail to respond to their needs. Similarly, no satisfactory explanation is offered as to why sufferers are mainly adolescent or why the illness should be increasing in other age groups as well. Also, there has been a considerable body of research demonstrating that attachments are fluid and that relationships with others can be as important as attachments to mothers (Dunn, 1993; Rutter, 1995). Lastly, and perhaps most importantly, the theory lacks specificity to AN and Bruch (1985) did not identify the developmental processes pertinent to BN because she questioned its inclusion as a separate diagnostic category. Her theory therefore fails to explain why two separate pathologies (according to DSM) should arise at the same historical juncture.

Some Feminist Psychoanalytic Approaches to Eating Disorders: Orbach and Bell
Bruch (1974, 1978) was not alone in adopting psychoanalytic thought as the basis of a theoretical approach to eating problems. Despite the long-standing and sustained feminist attack on Freud’s ideas, feminists began to reinterpret aspects of his theory to explain women’s social and relational difficulties. Baker Miller (1976, 1994), Chodorow (1989, 1991), Mitchell (1974) and Sayers (1982, 1990) have argued in favour of Freudian analysis as a valuable resource in the psychical understanding of both genders and as a means to deconstruct the personal and cultural oppression of women. Their belief that elements of Freud’s psychosexual theory of development could be incorporated into feminist theory and that psychoanalytic techniques could
be appropriated for use in the treatment of psychologically distressed women was welcomed by many practitioners working with eating disordered clients.

Notable amongst those who embraced the principles of psychoanalytic theory was Susie Orbach who has achieved recognition as an author of feminist works and as the therapist who helped Diana, Princess of Wales, with her eating problems. At a macro-level, Orbach (1985, 1993) has located the ultimate source of eating problems in the socially prescribed roles in which women are conditioned to participate. She believed that women experience their own bodies according to comparisons they make between themselves and the ‘thin-as-ideal’ media images that constantly bombard them; in this respect, she accords with the Foucauldian notion that social control is maintained by self-regulation and referral to the standards of others. She is also mindful of the post-war drive to return women to the domain of home and to a domestic servitude in which the care needs of others supersede their own requirements. However, rather than dismissing as politically motivated the mother blame which was attached to post-war conceptualisations of women and families, Orbach (1985, 1993) has engaged in a critique of the social conditions that have led to mothers being responsible for their daughters’ eating problems. At a micro-level, she has employed a psychoanalytic approach to argue that the preconditions for eating disturbances begin early in the mother/daughter relationship.

In common with Bruch (1974, 1978), Orbach (1985, 1993) identified the mother’s unwillingness or inability to respond to her daughter’s needs for nourishment and autonomy as fundamental to the development of an eating problem. Daughters, according to Orbach (1985, 1993), stir up conscious and unconscious reactions in their mothers who respond to them with a lack of consistency and attention. The symbolic expression of mother-love is reified in food and the feeding relationship becomes one in which, from birth, boys normally experience total gratification whereas girls learn a lesson of deprivation (Orbach, 1993). Although Orbach has attempted to explain the psychological mechanisms that culminate in individual experiences of AN and BN, she has been unable to integrate her macro and micro-level arguments in a coherent and convincing way. In treatment and in practice, girls and their mothers are viewed in isolation from the rest of their families and from society. Little account is taken of the
influence of fathers, siblings, extended family relations, peers or the school environment - all of which have been shown to have a significant influence on adolescent development (Adams et al., 1994). It might therefore be the case that a thoroughly systemic approach might be more helpful (Dallos and Draper, 2000).

Much of Orbach’s (1985, 1993) evidence is taken from anecdotal reports of client sessions in which mother blame is a salient feature. One wonders how else a troubled woman would interpret her position in relation to a daughter with an eating disorder in a society saturated by the accepted wisdom that mothers are responsible for their children’s psychological well-being. Benveniste et al.’s (1999) investigation into lay theories of AN has found that these theories reproduce and maintain existing concepts and practices that inform popular conceptualisations of the illness. Also, Orbach’s case for the centrality of the mother/daughter dyad to the specific mechanisms of AN and BN has been somewhat diminished by the assumptions of her latest novel. Although essentially fictitious, Orbach’s (2000) *The Impossibility of Sex* is a catalogue of case studies in which the mothers’ inadequacies leave their children scarred and dysfunctional. Her premise that discrete social factors can interact with the unconsciously motivated behaviours of mothers to produce specific pathologies like eating disorders seems to have given way to a more general psychoanalytic view that women’s psychologies are inherently defective.

When prominent supposedly feminist voices like Susie Orbach’s speak of the validity of traditional methods in the treatment of women’s distress, it can seem that mainstream theories are foundational to or can at least be incorporated into feminist thinking. Theories that draw upon and echo cultural assumptions such as mother blame can seem to be legitimised as feminist practice. Other psychoanalytic therapists have claimed to adopt a feminist approach to eating disorders, which in effect, appears to be indistinguishable from traditional psychoanalytic psychotherapeutic approaches. As an example, Karin Bell’s case study ‘On the relationship between daughters and mothers with regard to Bulimia Nervosa’ will be examined in some detail. Bell’s (1994) account of an adolescent’s development of BN appeared to be more concerned with the mother’s psychological state than with her client’s, whom she called ‘Martha’, and throughout the narrative there are clear references to the mother as the
source of the pathology. Bell (1994: 21) began by saying that it is ‘excessive stimulation in the early mother-daughter relationship which renders it impossible for the infant to withdraw’ and she seemed to concur with Bruch’s (1985) view that working mothers are unable to fulfil their daughters’ needs. Martha’s problems are constructed as arising from her own mother’s problems of individuation and separation and also from her mother’s return to work when she was aged three. ‘Martha’s model is a woman who only feels satisfied when she has a baby to look after’, she wrote (1994: 25). However, this point was contradicted in the next sentence when she stated that ‘Martha was born when her older sister reached the age of puberty’ (ibid.). Martha’s mother therefore had a gap of about ten years between her children, which does not suggest that she was a woman who was unable to sustain herself without caring for an infant. When Martha’s mother returned to work and enlisted her own mother’s help in caring for her daughter, this was perceived as over-identification and an inability to accomplish separation: ‘A further indication of the difficulties Martha’s mother has with separation and individualisation is that she returned to her own mother’s house shortly after her marriage’ (1994: 27).

Bell suggested that the age of three is an extremely difficult one for mother and child to negotiate and that ‘there are mothers who reject in this phase and mothers who monopolize’ (1994: 26). When it appeared that there were no apparent problems between Martha and her mother at this time, Bell wrote that ‘it is precisely the inconspicuousness of this phase which would seem to us to be an indication of a possible disturbance’ (ibid.). Due to the fact that Martha’s mother expressed some anxiety about returning to work, Bell (1994) concluded that ‘Martha’s mother is to a great extent committed to an excessive, motherly ego-ideal, including its negative individuation in favour of caring for others: she cannot handle disappointment and rage’ (1994: 28). Martha’s own recollection of her past was therefore restructured by Bell who offered another version, i.e., that there were infantile developmental problems, which is more amenable to psychoanalytic interpretation.

Even when Bell considered the effect of the paternal relationship on her client’s difficulties, it was with reference to the faults of the mother. Martha’s father was described as an alcoholic who had made disparaging remarks about her body.
However, Bell construed his position as being warranted by the actions of the women in the family: ‘While the women have a “really good” relationship, the men are more or less left out in the cold. The father is consciously left out of things’ (1994: 28-9). Martha’s father’s alcoholism was suggested by Bell (1994) to be symbolic of the family’s struggle to be free from emotional entanglement and it was therefore constructed as a response to his wife’s over-dependence. The mother then was positioned as the culpable source of her family’s dysfunction. This version of adolescent BN was located within the context of a feminist perspective on the grounds that it purported to allow for the effects of social expectations on woman as mothers, wives, caregivers and providers. These however, are the very social conditions it appears to ignore.

Orbach (1985, 1993), Bell (1994) and many other feminist therapists, including Baker Miller (1994), Chodorow (1989, 1991) and Sayers (1990) seem to face a common problem in both working within a psychoanalytic model of treatment and acknowledging women’s oppression and marginalisation within a male-oriented society. Although both Orbach (1985, 1993) and Bell (1994) accepted that cultural pressures may be implicated in the onset and development of eating disorders, neither has recognised that one of the most pervasive and pernicious assumptions informing women’s subjugation is that of mother blame. Perhaps this is because the notion of mother blame is so central to the psychoanalytic method that to disentangle it from the theory would involve re-examining the entire foundation on which that theory is based. In attempting to appropriate psychoanalytic concepts to explain the aetiology of eating disorders, some feminists seem to have engaged in a dialogue of mother blame, which may only reinforce the notion of mother as originator of psychopathologies. Seen in its historical context, this notion was alive in cultural assumptions at the same time as theories were being expounded about the nature of eating problems, just as, in Gull’s era, the notion of female hysteria was reflected in social thinking. In both instances, prevailing social discourses concerning disordered eating patterns have been absorbed into theories about aetiology, which in turn inform treatment practices.
Reconceptualising Eating Disorders: Social Constructionist and Narrative Perspectives

The radical psychoanalyst, Lacan (1979), criticised the language of psychoanalysis for reinforcing hegemonic values. He suggested that Freudian analytic terminology imposes a concrete and immutable reality onto the psyche which is represented as striving towards coherence and consistency when, he contended, it is actually perpetually divided against itself. This interpretation of the psyche as fluid, changing, adapting constantly to circumstances and expressed through a language that is jointly negotiated with others, raises concerns about the central premise of psychoanalytic theory that the monologue of the self principally informs every individual’s behaviour. Lacan (1979) has argued for a more pluralistic understanding of the self as socially influenced. According to Parker (1997: 483), the significance of Lacan’s interpretation for the delivery of psychoanalytic treatment lies in its widespread acceptance in practice: ‘The Lacanian school has at present...the allegiance of half the practising analysts in the world’, he has asserted.

The problem with Lacanian theory is that it continues to rely on Oedipal principles to explain normative development and it is therefore not specific to the expression of particular disorders like eating problems. Crucially though, it recognises the importance of discourse, a concept that is also central to social constructionist principles. One of the fundamental precepts of social constructionism is that people’s world views are created in historical processes and in interactions between dominant and marginalised groups of people (McLeod, 1997). It is therefore essential to the understanding of people’s world views of eating disorders to examine the historical and cultural circumstances in which these particular pathologies have been named and have arisen as part of the social conditions of the time. Social constructionism also takes a critical position on the taken-for-granted assumptions that maintain social hierarchies and it questions the traditional approaches that fail to examine those assumptions (Burr, 1995; McLeod, 1997).

One of the therapies that has arisen as a response to the philosophical stance of social constructionism is narrative therapy. It proposes that many versions can be generated about any single phenomenon or event and that these versions are jointly negotiated in
discursive interaction. Thoughts and behaviours are believed to arise from socially informed narratives about the self and these are reflected in language and speech. Narratives, then, are situated within a social context and are seen as jointly negotiated enterprises that provide a sense of meaning and understanding to human encounters. The therapeutic encounter, as part of this linguistic system of meaning-making, provides an opportunity to facilitate a dialogic process of co-creating opportunities for new narratives and alternative agencies (Anderson and Goolishian, 1992). By examining their narratives, clients can become aware of the taken-for-granted assumptions that have impinged negatively on their lives. As narrative practitioners, Swan (1999) and White (1991) help to alert their clients to the effects of technologies of the self and technologies of power. In their stories about themselves, their clients often report how they develop self-concepts by comparing themselves to others and by having a sense that others are continuously evaluating them. One such case is White’s (1991) client, known as ‘Amy’, who was experiencing problems with AN. By examining the ways in which she disciplined her life, Amy was able to recognise the attitudes that contributed to her anorexia and then to resist them by developing alternative narratives and knowledges that provided a different course for her life.

This approach has been criticised for its failure to attack the social problems responsible for individual suffering (Hepworth, 1999) and because it offers to help individuals who then must continue to live within the society that was apparently responsible for their oppression in the first place (Fish, 1993; Madigan, 1992). If these criticisms are accepted, then the option is either to ignore individual suffering altogether or to employ in treatment the mainstream approaches that are implicated in the reproduction of subjugation. Kitzinger (1993) and Kitzinger and Perkins (1993) have advocated the abandonment of the therapeutic enterprise in favour of political actions that would alter and equalise power relationships. Given that eating disorders appear to be socially engendered and reinforced dysfunctions, it seems likely that purposeful social restructuring would alleviate the problem. Unfortunately the numbers of women suffering from an eating disorder are currently reported to be at epidemic levels (Wakeling, 1996) and the consequences of political change are unlikely to be felt immediately.
Another consideration is the possible resistance to personal and political change amongst women generally and amongst women with eating disorders themselves. Those with eating disorders have been considered ‘difficult’ patients because of their attempts at avoiding the treatments imposed upon them and because of their desire to maintain low body weights (Lemma, 1996). The holy women of the 12th and 13th centuries literally embodied the social values of their time. Likewise, AN and BN sufferers today have adopted the socially prescribed philosophy of the self that is promoted in the culture of dieting and weight restriction (Bordo, 1993). Are eating disordered women today the fasting virgins of the Middle Ages who willingly deprived themselves of nourishment in the hope of greater social recognition? Are the sometimes painfully thin, waif-like female ‘stars’ of today the equivalent of the fasting virgins of the past, whose strict adherence to culturally sanctioned practices, including that of emaciating their own bodies, brought them status and glory? If so, then those who have successfully used this value system are unlikely to undermine it and those who aspire to use it may also resist change.

The desire to be thin is socially constructed as being laudable and necessary for women’s success (Bordo, 1993; Coward, 1987; Lawrence, 1987). The self-harming behaviours of women with AN and BN may have been adopted for what appear to them to be very sound social reasons and not because their mothers were inadequate or because, as in Freudian or Lacanian theory, their sexuality became problematic around the age of three when they realised that they were female. Feminist therapists need to acknowledge this. By using socially aware therapy (such as narrative and/or systemic approaches) to examine their immediate worlds, eating disordered women may become better acquainted with the multiplicity of social and personal factors that drive their behaviours and then choose to resist them or not.

[Personal Overview]
I am writing this overview two years after submitting this piece of work for comment by the Course Team and therefore my reflections may not be representative of other positions I might have adopted at that time. As a first year trainee who had never undertaken a project of such magnitude I found this task an extremely daunting challenge. As an undergraduate I had attained quite high standards - finishing with a
First Class Honours degree - nonetheless the first major research project undertaken at doctoral level was a sobering prospect. It should be noted that the Course Team were extremely helpful and supportive at this early stage of training, taking a long-term view of our research interests and where those interests might eventually lead us. One of the most memorable comments made by Dr Adrian Coyle, my supervisor, after reading a first draft of my work was, ‘where is your authorial voice?’ The mere asking of the question reminded me that I had been a long time without a voice and it acted as an incentive for the assumption of the committed epistemological stance that I took in this work.

The actual writing of this paper was a pleasurable and satisfying exercise. I had developed several interests whilst still an undergraduate and these included eating disorders, narrative therapies and feminist issues concerning religion, motherhood and reproduction. In one way or another all of these interests converged in this review of the eating disorders literature. Of course the perspective that I took in the paper was influenced by my previous studies and probably in particular by the women’s studies component I elected to undertake as part of my undergraduate degree. My decision to take up women’s studies was almost certainly influenced by the cultural and historical circumstances of my childhood development. I grew up in a small rural town in Ontario, Canada, where the overt monitoring of women’s behaviour was the strict norm. For instance, women who wanted to drink in a bar could only do so when accompanied by a man, normally a husband or boyfriend, who would take them through one of the two entrances these establishments were legally required to provide. One door was always clearly marked, ‘Ladies and Escorts’ and the other served as a warning to errant women who might be tempted to think about themselves as individuals in their own right. It said, ‘Men Only’ - this was also the name of a prominent pornographic magazine of the time, which I understand is still in existence today. This segregation and exclusion of women started early. Even my primary school had separate entrances for boys and girls and our playground activities reflected enforced gender distinctions. The boys played baseball or ice hockey while we girls held hands and watched, chanting rhymes and sometimes shouting encouragement from the sidelines. As girls we knew our place and it was considerably lower than that of our male counterparts. On reading this passage one
might be tempted to think that the writer must be really quite old, but this was not so many years ago – only as far back as the 1960s and 70s.

I didn’t take up women’s studies because I was outraged by these circumstances and I wanted to change the world. I was merely curious about what feminists might have to say about the ways that we lived in the past and the ways that we are living now. It was only after I had heard their stories and read their literature that I became passionate about improving the living conditions of oppressed or marginalized or displaced women. And then, yes, I did want to change the world. After all, I have served my time in small-town Ontario where being female meant having no place in the dynamic world and where women’s voices were silenced, especially if they threatened to be strong and authorial and they advocated change.]
References


Size Matters: 
Psychotherapeutic Discourses of Anorexia Nervosa

This study takes a social constructionist approach to the investigation of therapists’ accounts of Anorexia Nervosa (AN) and their own roles in its treatment. The research examined how these accounts were jointly produced in therapist and interviewer conversational interactions. Eight therapists – all currently working with AN clients - were interviewed using a semi-structured format. Transcriptions based on tape recordings of these conversations were made and analysed using discourse analysis. This analysis took a Foucauldian approach and was concerned with the ways in which dominant cultural ideas and assumptions are rooted in the maintenance of power relations. Several readings of the data allowed for the extraction of texts in which patterns related to therapists’ constructions and interviewer/therapist subject positions recurred. Three extracts were selected for the final analysis. Two extracts showed that therapists constructed anorexia as a disturbance of the ‘self’ passed from an ‘unhealthy’ mother onto her victimised daughter. In the third extract, the therapist contrasted constructions of a female client who is ‘saved’ from anorexia by her heterosexual romance, with a therapeutically ‘unsuccessful’ male client of anomalous gender traits. Criticisms were made of therapeutic discourses of ‘recovery’ that locate women within disadvantageous power relations.
Size Matters:
Psychotherapeutic Discourses of Anorexia Nervosa

Over the past forty years there has been an increasing cultural fascination with eating disorders and especially with Anorexia Nervosa (AN). This interest has been demonstrated in the widespread media coverage of all aspects of AN and links have been made between anorexia and the allure of catwalk fame and television stardom. For instance, actresses Calista Flockhart and Sarah Jessica Parker have been noted for their drive to achieve increasingly diminished body sizes. AN has therefore been endowed with a glamorous image associated with star status and professional success, thereby setting a standard against which other women measure their own social and personal worth (Bordo, 1993). Because the overwhelming proportion of those diagnosed with AN are women, feminists have been concerned with explanations that account for the gender-specific nature of AN and they have critically examined social and political constructions of the female body and its problematisation, particularly within the culture of medical science.

Bordo (1993), Hepworth (1999), Lawrence (1987) and Ussher (1989) have identified female biology as a site of women’s oppression and demonstrated that a number of interrelated cultural factors are connected with an increase in distressed eating practices. According to Parker (1999) and Parker et al. (1995), dominant cultural ideologies are reproduced in psychological theories of the mind and body and in the therapeutic practices that evolve from them. It is perhaps unsurprising, then, that together with the public preoccupation with AN has come an intensified medical interest in the psychological study of eating ‘disorders’. Anorexia has been the subject of extensive research, treatment planning and resource allocation in both the NHS and in private clinical practice. Although there is no consensus as to the number of people currently struggling with an eating problem, there is agreement that the problem is widespread (see Bordo, 1993; Wakeling, 1996). It seems likely, therefore, that most counselling psychologists at some point within their careers will encounter patients diagnosed as eating ‘disordered’.
Attempts by psychologists, psychotherapists, psychiatrists and other clinicians to account for the phenomenon of ‘disordered’ eating have resulted in paradigmatically modernist approaches to treatment (see Garner et al., 1997; Treasure, 1994). According to these models, inner psychic processes are held to be crucial to the experience of a disturbed body image, which results in a weight phobia (for instance, Rosen, 1990; Slade, 1994). The modernist view is that eating behaviours become disordered as a result of dysfunctional cognitions, schemas or concepts and that they require alteration so that more functional patterns of eating can be initiated. This trend towards cognitively-oriented psychotherapies has developed, even though it cannot be demonstrated that any single or combined treatment or approach alters the AN sufferers long-term eating behaviours (Hepworth, 1999).

Often other modernist models are drawn upon in order to complement the cognitive-behavioural view currently favoured within the medical culture. Psychodynamic approaches have been developed with the specific intent of accounting for ‘maladaptive’ eating practices. This theory suggests that the AN sufferer develops an eating problem as a means of preventing the maturation process and to avoid becoming a sexually functioning adult woman (Crisp, 1988). Bruch (1974, 1978, 1985) incorporated the notion that disturbances in eating patterns are the result of a mother’s inadequate response to her child’s feeding and emotional needs. Treatment programmes therefore often include a component of family systems therapy (see, for instance, Selvini Palazzoli et al., 1978). Strategies based on this modernist paradigm have done seemingly little to impact positively on either the severity of symptoms or on the numbers reported as suffering from AN and it is therefore unsurprising that treatments are often regarded as unsuccessful (Fleming, unpublished manuscript, Sacker & Zimmer, 1987). The predominant medical approach endorses a view of objective ‘truths’ and causal ‘facts’ about AN but these theories have left startling omissions concerning aetiology. For instance, between 90% and 95% of sufferers are women, many of them adolescent and the theories upon which treatments are based

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1 Earlier Freudian theories explained AN in terms of fantasies of oral impregnation (Rachman et al., 1939; Waller et al., 1940).
2 AN has the highest mortality rate of any condition categorized as psychiatric with deaths occurring in up to 15-20% of the affected population (Crisp et al., 1992; Sacker & Zimmer, 1987) and its incidence is reported to have increased annually since the 1960s (Pawluk & Gorey, 1998).
fail to provide a convincing rationale for the age or gender-specific nature of the illness (Bordo, 1993; Malson, 1998). Also, it is often the person, rather than the intervention, that is perceived as problematic when treatments fail to have a positive impact on the sufferer (Garner et al., 1997; Lemma, 1996; Selvini Palazzoli et al., 1978).

[My own experience of working with AN clients prior to beginning to study for the PsychD was that they were often baffled by their own food refusal. Despite this confusion, I was expected to begin treatments with an approach that required, and sometimes demanded, that clients accept their thought processes as maladaptive. This was customary even though the social messages they received in newspapers and in magazines, on television and through the media generally indicated that, to coin a phrase, 'you can never be too rich or too thin'. Rather than focusing on the meaning of the client’s eating practices for them, I was taught to ignore the social cachet that is attached to extreme thinness. Outside of the therapeutic context, I knew that size mattered greatly and that women were under tremendous pressure to conform to ideals of thinness that were attainable to only a small percentage. Inside the therapeutic setting, extreme thinness was pathologised as arising from within the individual and I was left feeling caught between two paradoxical worlds.]

Against the backdrop of the traditionally scientistic medical paradigm being employed in the treatment of AN are recent movements amongst psychologists - particularly in the area of social psychology - towards post-modern, social constructionist analyses. This shift from the modern to the post-modern involves a change of focus from the internal world of the person onto their external, social interactions or ‘doings’. In particular, speech acts and discursive practices provide a locus of interest for social constructionist interpretations of the ways in which people make sense of their worlds. Everyday assumptions concerning inner processes that speculate about the ‘mind’ or about the ‘self’ are challenged, whereas the study of spoken norms, rules, rituals, customs and habits is privileged. As part of this re-evaluative process, the medical model of psychological function is unsettled and its biologically-based postulates are questioned in social constructionist critiques. Studies that articulate a social constructionist epistemology often rely on the theoretical writings of Foucault (1983,
1988), whose analyses illustrate how dominant ideas are rooted in the cultural maintenance of power relations.

Adopting a Foucauldian rationale, Davies and Harré (2001) and Harré and van Langenhove (1999) illustrate and interpret how moral orders can be established and maintained in speech acts. According to Davies and Harré (2001), social positions are 'the discursive process whereby selves are located in conversation as observably and subjectively coherent participants in jointly produced story lines' (p.264). As a product of the sociocultural context in which they appear, those story lines are likely to reproduce meanings constructed from within a broad social environment and which reflect local moral norms. Speech acts concerning AN are therefore constitutive of the social positions open to the AN sufferer and those involved in their treatment. The study of discourse, through the method of discourse analysis (DA), has explicated some of the socially shared meanings surrounding AN.\(^3\)

Most analyses have focused on client discourses, for instance analysing constructions of identity related to practices of self-starvation (Walstrom, 2000). But what of the subject positions occupied by practitioners working with AN? They too will be subject to the rights and responsibilities generated from within local moral customs and occurring within situated interactions and co-constructions (see Potter & Wetherell, 1987). This is an area of psychology that has been little explored as constructions of the AN client, often made by the AN client themselves, have been foreground in most DA research. An examination of therapists' conversational rhetoric concerning AN may therefore generate new understandings of professional constructions and also illustrate the ways in which these interactional accounts are accomplished. Additionally, therapists’ accounts of AN constructed within their interactional context - for instance, examining therapist-to-researcher discourses and researcher-to-therapist discourses - may aid the understanding of how such accounts are jointly produced.

\(^3\) For example, Hardin (2001) has examined processes of self-starvation and self-surveillance; the death and dying of the anorexic body has been explored by Malson and Ussher (1997); and potential meanings of recovery have been articulated by Walstrom (2000).
Research Aims

The current research aims to explore the diversity of potential discursive resources drawn upon by therapists and to investigate the constructions of anorexia that emerge from within therapists' discourse. Inevitably, through the co-construction of narratives, interpretive possibilities will be opened up or made available to the therapist and other possible areas of conversation will not be explored or will be closed off (see Potter, 1996; Wetherell, 1998). This research also aims to make explicit those discursive resources being drawn upon by therapists and which bear upon the therapeutic process – both in terms of the ways in which AN is problematised from within the research interview and also regarding the ways in which therapists position themselves relative to their clients. The research will explore how therapists’ constructions of AN are contrasted with their construction of those maintaining ‘healthy’ eating practices. Additionally, it will focus upon the therapists’ positioning in their talk about their work and it will also attend to the positions of both participants within the interview.

An examination of conversation that explicates the repertoires drawn upon by therapists who work with AN is of interest to counselling psychology in several ways. Firstly, it strives to make transparent some of the assumptions and expectations of those described as having the ‘pathology’ anorexia, held by those who have significant social and - for their clients - personal influence in this area. Potentially, the discursive practices invoked in therapist elaborations of AN will be endorsed by a complex health care network. Consequently, should therapists position themselves relative to a particular ideological framework, this could affect assessment of the client’s suitability for therapy, the treatment processes thought appropriate and also - most pertinent to the client/therapist endeavour - the evaluation of therapeutic outcome.

Secondly, this research may yield fresh insights into the therapist’s position as ‘helper’ or ‘facilitator’ in relation to the client with AN. It is possibly through an elucidation of their own discursive practices that therapists working with AN may be better enabled to grasp more fully what it is they are ‘doing’ in therapy. Finally, such research may contribute to current debates in which narrative, constructionist
therapies (see McNamee & Gergen, 1992; McLeod, 1997; White, 1991) are contrasted with more traditional approaches. The former explore a number of narrative possibilities within the therapeutic space whereas the latter are concerned with replacing the AN sufferer's 'maladaptive' schemas with more functional ones. Therapists’ constructions of their role in facilitating client change may elaborate this debate on therapeutic function.

Method

Participants
Psychologists and psychotherapists who specialised in the treatment of those diagnosed with AN by a qualified medical practitioner - a GP, psychiatrist or other - were selected for participation in the study according to their range of experience with AN. A total of eight were interviewed: four psychotherapists, two consultant clinical psychologists and two counselling psychologists (all are described as 'therapists' throughout this paper). Four of the interviewees were working in private practice, three in NHS specialist units and one in both the NHS and private practice. Four participants described themselves as integrative therapists, one as a CBT practitioner and three as psychodynamic. All participants were female; seven were white and one was Asian. Ages ranged from 39 to 59, with the mean age being 51. Number of years in practice ranged from nine to 22, with the mean being 15.5 years.

Procedure
Permission to undertake the study was granted by the University of Surrey’s Advisory Committee on Ethics (see Appendix A). The interviews were conducted by the researcher, a third year trainee in Psychotherapeutic and Counselling Psychology, whose demographics were not dissimilar to those of the majority of participants. Although I am a Canadian, like most of the interviewees, I am a white, middle class woman and therefore to some extent I represent the profile of the typical therapist working with anorexia.

Prior to undertaking the interview, each participant signed a consent form authorising the use of the data for research purposes. (See Appendices B and C for consent form and demographics questionnaire respectively.) They were informed that the
interviews would be audio taped and transcribed (see Appendix D for a sample transcript) and that they should change some of the details of cases being reported in order to preserve the anonymity of their clients. A semi-structured format was adopted for the interviews as this allows flexibility of questioning within a fixed area of topical exploration. The interview schedule was developed to include questions that encouraged therapists to elaborate on AN and on their own roles in its treatment. Questions focused on therapists' views of the cause/s of AN, their perceptions of their own role in treatment plans and on their interpretations of therapeutic success (see Appendix E).

The interviews were conducted at the therapist's place of work and the length of the interviews ranged from 45 to 75 minutes, the mean length being 60 minutes. Interview tapes were transcribed using transcription conventions developed by Atkinson and Heritage (1984) (see Appendix F) and preliminary data selection procedures followed those suggested by Potter and Wetherell (1987). The transcripts were anonymised in order to protect the confidentiality of the therapists and their clients. In order to preserve confidentiality further, therapists are referred to by an initial throughout and I am referred to as the interviewer.

**Analytic Approach**

Discourse analysis is the method of analysis that most appropriately corresponds to the social constructionist epistemology of the current research. Davies and Harré (2001) and Harré and van Langenhove's (1999) theory of social positioning is rooted in the Foucauldian school of DA, and the present work therefore took this approach. Although preliminary stages of analysis were guided by Potter and Wetherell (1987), Parker's (1999) critical approach to the analysis of discourses informed this work. Initially, several readings of the data were made and passages related to therapist and interviewer subject positions were extracted, as were constructions related to the AN client. These early readings were particularly monitored for instances of therapists' subject positions relative to their own roles in the treatment of AN. Closer readings yielded instances of recurrent patterns within the therapists' discourses. More detailed examinations of these passages allowed for the extraction of recurrent subject positions and themes were identifiable within these. Finally, three extracts that
appeared to best represent the body of text were selected. Material from only three therapists was used for the final analysis. Working hypotheses were formulated from the selected extracts and inferences were drawn about the possible implications for psychotherapeutic practice.

**Evaluation of the Research**

Although the epistemological stance of different methods of analysis will affect how validity is assessed, it is essential that this should be evaluated whether working within a qualitative or quantitative research paradigm (Osborn & Smith, 1998; Smith et al., 1996). DA does not endeavour to identify a single, generalizable ‘true’ version of findings from the data. Rather, it aims to provide a systematic account of the discursive practices employed within the data. Yardley (2000) suggests that four criteria are appropriate to the evaluation of qualitative research, including discourse analytic work. They are sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. It is her belief that rhetorical persuasiveness and the impact and utility of research are critical features of any psychological work and should be evaluated to determine the importance of a study to the body of knowledge. In order to attend to the issues raised by Yardley, colleagues familiar with this were consulted within a DA research group regarding interpretations being placed upon the data. This also insured against potentially idiosyncratic analyses of the text. The reader is invited to ‘interrogate’ the interpretations placed upon the data and to assess the paper’s importance by means of its rhetorical persuasiveness and its contribution to the existing body of knowledge.

**Analysis**

Throughout this interview, Therapists A’s narrative was concerned with the notion of agency in a number of ways. Primarily, the AN client’s agency in relation to her mother was problematised as Therapist A drew upon repertoires that pathologised the daughter/mother relationship as being overly-enmeshed and causal to the development of distorted eating behaviours.
Therapist A: I am absolutely fascinated with this idea that what the people who suffer from anorexia have been their mother’s transitional object.

Interviewer: that people who suffer from anorexia

Therapist A: [anorexia]

Interviewer: have been their mother’s transitional object

Therapist A: [object] or are their mother’s transitional object. (...) so what that implies that I see this because we are dealing with young patients and we have a lot to do with their mums and dads of course (...) it’s the the I mean this case I was just talking about is a case in point, the CHILD in the mother’s frantic attempts to make sense of her sort of internal world and decide where her boundaries are and things the child is playing a role for her

Interviewer: Uh huh

Therapist A: and so this fits with the child not being able to separate from mum mum can’t allow her to separate. hh I mean you know children who are insecure need their teddy bears you know er sort of sort of that is an archetypal transitional object (...) they need to be able to be in charge and to control it and they are DE:solate if they can’t see it or it is thrown away or something like that

Interviewer: so you are saying that for the mums the child is the teddy bear

Therapist A: yeah

Interviewer: that that has to be held on to

Therapist A: yeah yeah and is a sort of a way that I mean the teddy bear the sort of healthy way of having something outside your body that you feel very very still very much part of you and which gradually you can discard and it helps you to define your sort of boundaries you know th: th it’s it’s not me it is a teddy bear and gradually as I grow up I will get rid of it

Interviewer: so that is part of the psychology is that the mother does then get rid of the teddy bear or

Therapist A: no I think it is more that you know the children are so important to the mother that they don’t they DON’T get rid of the teddy bear (...) (laughing) I mean you know this is true for anorexia they can’t because they end up with this very ill child and then they can’t throw it away but I mean I mean the thing is the the child is SO important to the mother not in a sort of a healthy mother-child sort of way, but in the
fact that the child is fulfilling some function for the mother which keeps her feeling
more secure in HER: self. (..) THAT that fits for me
Interviewer: does that I mean I don’t know if you have sort of translated that to your
(...) patients does that (...) fit for them do you think or
Therapist A: it might explain why they are terribly terribly suspicious of therapy or of
anybody (..) I can think of another one who is terrified of me um trying to analyse her
as she puts it (..) everything SAY she says you try and analyse and you make
something of (..) she finds it ab and she is absolutely petrified of that um (..) and so I
mean presumably her fear is that if I (..) um (..) I mean I think I am understanding and
she thinks that I am getting her wrong but WHAT: ever it is it has given me some sort
of control over her or something like that (..) she is giving UP it is like she feels she is
giving up part of herself if I am thinking about (..) what she might mean when she says
something you know it’s not safe for her to allow anybody (..) except her mum in fact
(..) to help her understand her:SELF

Initially, Therapist A draws upon a Freudian analytic discourse of psychological
inertia or non-movement in which the transition from psychic craving to fulfilment
cannot occur because of unresolved psychological needs. Because Therapist A
invokes this psychoanalytic discourse without providing a detailed explanation of it,
she positions the interviewer as an informed hearer, or as a ‘professional’ insider with
an assumed knowledge of the theoretical stance. The proffered discourse is based
upon Winnicott’s (1986) concept of the transitional object, which he proposed is
created by the infant as a symbol of “its confidence in the union of baby and mother
based on the experience of the mother’s reliability and capacity to know what the baby
needs through identification with the baby” (p.50). Therapist A turns this theory on its
head when she constructs the mother as infant, whilst the infant is, in turn, constructed
as provider of psychological security (line 2): “people er who suffer from anorexia
have been their mother’s transitional object (..)”.

Therapist A moves from the first person “I” to the inclusiveness of the professional
“we” as she suggests that the use of the anorexic by her mother is a visual
phenomenon that can be observed not only by herself but also by other professionals:
“I I we see this because we are dealing with young patients and we we have a lot to do
with their mums and dads” (line 8). Having established her status as a member of a professional group, Therapist A is enabled to move back into the first person “I” in order to warrant her claims about her own patient who suffers at the hands of her mother, saying, “this case I was just talking about is a case in point” (lines 8-9). The client’s mother is then constructed as “frantic” (line 10), “DE:solate” (line 16), as a person who cannot “make sense of her sort of internal world” or “decide where her boundaries are and things” (lines 10-11). The inclusion of the words “and things” suggests that this particular mother has additional defects that are perhaps too numerous or too problematic to be elaborated at the present time.

The therapist warrants her metaphor of the mother as insecure infant and the child as her comforting toy by once again invoking a psychoanalytic discourse in her repetition of the word “separate” (lines 13-14), which alludes to the theoretical task of adolescents to ‘separate’ and ‘individuate’ from their parents. She also uses the phrase “archetypal transitional object” (line 15), again interspersing therapeutic jargon into the conversation, which positions both the therapist and the interviewer as informed members of a professional community. A potentially problematic moment occurs in lines 23-26 when a contradiction arises in Therapist A’s narrative. Employing the Winnicottian perspective, she has suggested in lines 24-25 that functional dependence and independence can be negotiated through the use of the transitional object: “it is a teddy bear and gradually as I grow up I will get rid of it”. However, when the possibility of independent functioning is applied to the mother by the interviewer in lines 26-27 (“so that is part of the psychology is that the mother does then get rid of the teddy bear or”), clarification to the contrary is made in lines 28-29: “the children are so important to the mother that they don’t they DON’T get rid of the teddy bear”. The therapist thus resists the interviewers attempt to reconstruct the transitional object as an aid to the mother’s psychological well-being. The anorexic’s mother is contrasted with other more functional mothers in line 32 when Therapist A states that her interest in her child is “not in a healthy mother-child sort of way”. The interest of ‘healthy’ mothers in their children is thereby legitimated whereas the interest of the anorexic’s mother is constructed as self-serving.
Towards the end of this passage, the interviewer questions the legitimacy of her theoretical claims and invites Therapist A to talk about if, and how, her theory is delivered to her clients: “does that (..) fit for them do you think or” (line 36). This raises a potential dilemma for the therapist concerning the disparity between the theory and practice of therapy for AN. As part of a system of medical ‘experts’, the therapist has been positioned as one who should provide an explanatory account of the relevance of her theory to her clients. If Therapist A were to indicate that her clients find merit in her application of this theory in their treatment, it would suggest their cooperation with her therapeutic endeavours. This would be a problematic claim for the therapist as one of the predominant narratives of eating disorders practitioners concerns the failure of anorexics to comply with treatment (Lemma, 1996).

The therapist’s response to this dilemma is to pathologise the anorexic’s mistrust of her attempts at treatment and to describe her as having an undue level of fear: “it might explain why they are terribly, terribly suspicious of therapy or of anybody” (lines 37-38). By adding “or of anybody”, the therapist diminishes the importance of the therapeutic context in the client’s mistrust – anorexics don’t trust anybody, so why would they make an exception of the therapist? The client is then defined as “terrified” (line 38), “absolutely petrified” (line 40) and “it’s not safe for her to allow anybody (.) except her mum in fact (.) to help her understand her:SELF” (lines 45-46). Again a general inclusiveness prevails within the therapist’s narrative when she depicts the client as not being able to allow “anybody” to understand her. Burman (1997) notes that blaming mothers for their child’s bad or uncooperative behaviour is a standard discursive resource commonly drawn upon in social conversations. Here it is reworked as a therapeutic explanation for the client’s failure to co-operate in the therapeutic process. By reintroducing the dysfunctional mother/child relationship, Therapist A constructs anorexia as a disturbance of the self, passed from mother to daughter. However, the logical progression from an unhealthy and enmeshed mother/daughter relationship into the development of weight phobic eating practices is not elaborated.

Therapist A has set up a particular theoretical framework for the aetiology of AN, as a problem including the mother as pathologically attached and the child as a victimised
toy, subject to the unfulfilled needs of her mother. She positions herself as a person entitled, through the therapeutic relationship, to challenge the mother's place in the corrupted mother/child dyad. The mother, as needy child, is constructed as being psychologically 'static' and unable to move beyond her desperate need for her 'transitional object'. The client is constructed as being agentically thwarted, having developed a mistrust of all, including even those whose interests lie only in helping her. This construction of anorexia is applied not only to those specified within the therapist's clinical examples but it is generalised across all 'difficult' AN patients and utilised as a universal description.

Extract 2

This extract is also largely concerned with agency and in particular regarding the negotiation of agency between the client and the therapist. In common with Extract 1, the dialogue concerns the client's psychological enmeshment with another. In this case, the attachment to the therapist sought by a particular client is metaphorically described as parasitic in character. This construction is developed as a contrast between a 'successful' therapy, wherein little or no enmeshment occurs, and an 'unsuccessful' therapy in which the client clings, unhealthily, onto the therapist. Psychoanalytic theory privileges a developmental model of psychological functioning, suggesting that behavioural patterns learned in childhood are repeated in adulthood. Known as transference, it provides a resource for the explanation of the client's feelings toward the therapist. Throughout this passage, Therapist B draws upon a psychoanalytic discourse, invoking assumptions of transference, in order to develop her construction of the anorexic client as 'leech' (lines 24 and 26).

1 Interviewer: mm mm yes mm (.) I wondered if you could give an example of
2 successful therapy, where you felt it it had worked really well and (..)
3 Therapist B: [laughs] when I was working with somebody recently who (.) who:oo
4 was (...) got a got a TWO ONE finished, completed her course, knew what it was she
5 wanted to be DO:OING (coughs) and had moved into a flat with people she liked and
6 respected her who appreciated her boundaries.
7 Interviewer: uh:hh

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Therapist B: uhh. (...) then I really felt and was able to keep her mother or her FEELINGS about her relationship with her HER MOTHER when they met again and the same old thing happened she was able to realise that it was her mother's (...) Interviewer: uh.

Therapist B: u:uh. (...) I just hoped underneath the food was ok

Interviewer: mm. Mm (.) so the success was in the way she was able to carry on

Therapist B: her life, rather than someone else's life

Interviewer: right (.) uh huh because that is something you have been particularly talking about um and I suppose then it makes sense in terms of the merger that she was able to (.) to move away from that symbiotic relationship with you and develop

Therapist B: WELL she didn’t become symbiotic with me

Interviewer: uh huh

Therapist B: sh:she and I developed a more maybe she did in the beginning but she resisted it (.) she and I were always able to work (.) yes in the transference there was always well she really trusted me but she trusted me (laughs) she was a little bit separate she didn’t become the (...) LIM:pet that this other anorexic I just talked about feels like leech

Interviewer: mm mm

Therapist B: (.) sometimes I feel that she is a leech and then I am losing my (.) life blood.

Interviewer: sort of a host

Therapist B: yes

Interviewer: for her to feed off mm mm (...) Therapist B: this is interesting it is like I am (laughing) doing some supervision while I am talking to you

In this segment the client is discussed relative to her social accomplishments: “moved into a flat with people she liked and respected her who appreciated her boundaries” (lines 5-6). The invocation of the word ‘boundaries’ suggests a psychoanalytic repertoire in which the client is constructed as an individual self who has accomplished the psychological task of separating from others. In other words, the client is one who has agency and can relate to others with maturity and assertiveness.
Having drawn upon this psychoanalytic discourse, the therapist then continues with its development by introducing the notion of the problematic mother/child relationship.

Therapist B moves the psychoanalytic discourse from one acknowledging the client’s generally ‘boundaried’ self into a discourse that identifies the mother/daughter dyad as a problematic struggle. She constructs the client as oppositional to her mother in lines 8 and 10 respectively, “was able to keep her mother” and “was able to realise that it was her mother’s”. Thus, she relies upon a rhetoric of therapeutic success as related to the therapist’s skill in separating the two. Therapist B constructs herself as being crucial to the client’s ability to separate from her mother – “then I really felt and was able to keep her mother” (line 8) – as she draws upon the notion of repeated patterns of behaviour to account for the client’s problematic interaction with her mother – “and the same old thing happened” (lines 9-10). A Freudian discourse – privileging the psychoanalytic view that making unconscious behaviours known to the conscious mind can act as a curative process – is suggested in Therapist B’s statement that “she was able to realise that it was her mother’s” (line 10). By constructing the client as one who cannot operate as a psychologically separate self whilst falling prey to her mother’s “same old thing” (line 10), the therapist rhetorically positions herself as knowing and understanding that the relationship between the two women has damaged the client. Furthermore, it reifies the danger that a mother presents to her daughter, therefore rendering appropriate the therapeutic agenda to enlighten the client as to this danger.

The interviewer co-operates in the development of the discourse unfolding, possibly as a means of indicating that she has understood its implications, when she speaks of “merger” (line 16) and the “symbiotic relationship” (line 17). The interviewer has therefore been positioned and embraces the positioning of herself as an ‘informed’ conversational participant, but a problematic moment emerges. This follows the interviewer’s validation of the therapist’s discourse when she resists and challenges the negative connotations being placed upon her example of clinical success: “WELL she didn’t become symbiotic with me” (line 18). Therapist B then provides a contrast between the ‘successful’ client and a client whose demands of her resources are construed as overwhelming and inappropriate. The ‘unsuccessful’ client is presented
as a vitality-draining, parasitic “LIM:pet” (line 23) and “leech” (lines 24 and 26) that nurtures herself upon Therapist B’s very “life blood” (lines 26-27). A horror-story narrative akin to that of blood-sucking vampires of the gothic genre is invoked and herein (lines 23-30), the notion of merger and symbiosis is reconstructed. There is movement from the potential meaning of the symbiotic relationship as one that is harmonious and mutually beneficial, into its construction as a depletion of the therapist’s resources. Therapist B has positioned herself as one who provides sustenance and nourishment to the client who is consequently constructed as unreasonably demanding. The implication of the leech metaphor is also that it is the therapist who suffers when therapy fails.

At the end of this passage, there is a sudden and marked shift in the conversational footing: “it is like I am (laughing) doing some supervision while I am talking to you” (lines 31-32). This rhetorical manoeuvre on the part of Therapist B has two likely dialogic functions. First, it signals that Therapist B is unwilling to continue with the exchange as it is unfolding and second, that she is candidly acknowledging the joint production of the storyline. She is saying that the conversational structure resembles that of supervision sessions when one professional, normally of advanced experience, advises another on case management. Previously, Therapist B, in her horror-story narrative, had made an extreme case formulation. She constructed the therapeutic encounter as exhaustive, attacking, stressful and possibly even frightening. These are strong emotions that have been encountered by Therapist B in her professional persona, according to her account.

Part of the process of ‘doing’ therapy and of adopting a therapeutic discourse is to acknowledge within the supervisory context that powerful emotions arise as a corollary to working with those labelled as psychologically distressed, disturbed or pathologically-functioning. This rhetoric deems such ‘emotional’ narratives useful to the personal and professional development of the clinician (see Heimann, 1950; Kahn, 1997; Pick, 1985; Racker, 1968). Therapist B’s comments might then be read as context specific in the sense that both she and the interviewer are familiar with this supervisory framework. By invoking this rhetoric of professional/personal development, Therapist B positions herself as one who is not only entitled to voice
strong negative and critical feelings about her patients but as one who is at liberty to share these views with other professionals.

Extract 3
Like the preceding extract, this passage concerns a comparative discourse of a 'successful', followed by an 'unsuccessful' therapy. In the first instance the client is female and in the second the client is male. Therapist C constructs the female client within the commonly available cultural discourse of the fairytale wherein the heroine is triumphantly redeemed and saved by her (hetero)sexuality. The male client, on the other hand, is constructed according to a rhetoric of complex and troublesome biology. He is depicted as being failed by his problematic 'queer' sexuality and as being left alone to cope with his overwhelming gender-related physical problems. Fairytales have been described within feminist literature as expressing a number of psychosexual realities, primarily related to the agency of the males and the passivity of the females within the story. Constructions of character are normally dichotomous with the principals being either entirely bad or entirely good and without character development as the story unfolds (Bottigheimer, 1987; Lurie, 1990).

The connection between psychoanalytic theory and the fairytale has been long established by psychoanalytic practitioners including Bettelheim, (1989), Irigaray (1993), Horney (1950) and others. A Freudian psychoanalyst, Bettelheim (1989), has argued that fairytales offer a positive psychological means through which childhood conflicts of sexuality and identity can be processed and resolved. For instance, he posits that in the story Rapunzel, the heroine is able to escape her captivity by using her body in order to be saved by her lover and that this provides a useful model of psychosexual development to the children reading the tales. In Therapist C’s narrative, the fairytale formula is apparent as she constructs her client as a worthy heroine who cannot escape her predicament without the aid of a “WON:derful man” (line 4). In contrast, no such redemption can be found for her unsuccessful male client who refuses to accept treatment for his supposed somatic abnormalities.

1 Therapist C: she had had anorexia for donkey’s years (.) she had been a ballet dancer
2 and she had a very abusive relationship with a man and she was er I had only seen her
about half a dozen times and she really had worked hard and she tried very hard to change some things um but then she met this WON:derful man (..) and he just she was a lovely lady she really was she has gone on to help other anorexics now (.) but uh he turned her around (…) there was no doubt about it he definitely turned that woman around (..) well he DID (…) they met accidentally at Primrose Hill which was very romantic (laughing) apparently

Interviewer: yeah yeah

Therapist C: and she had lost her ring (..) and she was looking for it (..) and he found it and that is how they got talking you know um SO it is just something something which gels and she started to eat (.) almost immediately and her weight went up to a very respectable weight and and when I last saw her she was (…) slim perhaps only a BMI of about sort of 18, most people think you should be about 20 (.) but to me it is fine if you have been 11 or 12 (.) that is enough, that is fine

Interviewer: [Mm mm MM]

Therapist C: so that was another success another failure if you want one would be a boy who was also a male ballet dancer and um nice bloke (.) looked very feminine, very feminine voice probably very low on testosterone but didn’t want any help with that (.) again his parents were separated he had a very normal sister who was very nervous and anxious but still but apparently functioning very well (…) and he had developed anorexia at ballet school (,) and he felt that he had bow legs as he called them that his physique was not beautiful enough for a ballet dancer and that the college the Royal College I think the Royal Ballet School

Interviewer: Mm hm

Therapist C: and he had been persuaded that he needed to lose MORE weight so that his chest would be more in proportion (,) it’s something to do with ballet schools of course and something happened (..) I’m not sure exactly what it was I think he was (..) taunted by some boys at the school about being queer something like that I think that’s the way he put it and then something else had happened and he got VERY depressed and he he had a suicide attempt (,) which was very minor then he just went right on into anorexia (.)

This extract begins with a description of the female client as a ballet dancer, an occupation that, for a woman, embodies the culturally desirable qualities of
femininity, grace and charm. A sinister male character is then introduced in the form of her “very abusive relationship with a man” (line 2). Therapist C constructs her role in the treatment as minimal in lines 2-3 – “I had only seen her about half a dozen times” – possibly explaining why she had failed to have greater therapeutic impact on her client and why, therefore, her client needed to be rescued. This client is defined by the therapist in terms of her virtues, which are emphasised by such repeated terms as “really” and “very”: “she really had worked hard and she tried very hard” (line 3). Also, “she was a lovely lady” (line 4-5) whose virtues are deployed in the service of others: “she has gone on to help other anorexics now” (line 5). The use of the term ‘lady’ reinforces this client’s association with feminine virtues as it implies a status not conferred upon those referred to as ‘women’ or ‘girls’ or ‘females’.4

Having established that her client is deserving of a masculine saviour, Therapist C introduces the “WON:derful man” (line 4) who “turned that woman around” (lines 6-7). A picture emerges of a “very romantic” (lines 7-8) scene at the top of a hill in which the hero helps the distressed lady to find her ring – a traditional symbol of male ownership that invokes cultural associations to marriage and ‘happily ever after’ togetherness. As if by magic then, the client “started to eat (.) almost immediately and her weight went up to a very respectable weight” (lines 12-13). Despite this description, the client remains unusually thin “perhaps only a BMI5 of about sort of 18” (lines 13-14). Therapist C has therefore constructed herself as one who values thinness, even when others are more rigid in their expectations: “most people think you should be about 20” (line 14). She is also invoking a discourse of power. As medical practitioners, Therapist C and her colleagues are endowed with the power to determine the limits of acceptable body size. As a member of this medical community, Therapist C is able to ‘bend the rules’ and deem her client’s weight adequate, although others may not. Despite having had almost no therapeutic input with this client, Therapist C positions herself as able to claim clinical effectiveness: “so that was another success” (line 17). The fairytale format warrants an account of

4 Feminist literary scholars have written extensively on the use of various descriptive terminologies in discursive constructions of masculinity and femininity. For example, see Cameron (1998) and Coates (1993, 1996, 1998).

5 BMI refers to Body Mass Index, which measures the relationship between a person’s weight and height. Medical models suggest a ‘normal’ BMI should range between 20 and 25. (See Pietrobelli et al., 1994).
anorexia as a particularly feminine frailty. The anorexic is constructed as a weak and frail princess who, despite her best efforts, succumbs to the lure of self-denial, even after she has been ‘saved’. As a princess, she is to be imitated: as a role model her message to women is of self-sacrifice.

In contrast to her worthy, sexually appropriate and successful client is Therapist C’s example of therapeutic futility. This is “a boy who is also a male ballet dancer” (lines 17-18) but he is one who refuses to allow his inappropriate gender traits to be improved: “didn’t want any help with that” (lines 19-20). The therapist has emphasised that he is male despite having just described him as a boy, indicating that his gender is noteworthy in the context of his profession as a dancer. Before defining his physical characteristics, Therapist C describes him as a “nice bloke” (line 18). This is a form of stake inoculation, minimising the illocutionary force of her next statement, which might be read as critical. She reports that he is both visually and biologically anomalous: “looked very feminine very feminine voice probably very low on testosterone” (lines 18-19). The client’s sexuality is therefore constructed as a medical problem with a possible medical solution that is resisted by the client and he is thereby constructed as blameworthy for his ongoing difficulties. What was not constructed as problematic for her female client – namely, her description as a ballet dancer – is constructed as having serious pathological consequences for her male client: “it’s something to do with ballet schools of course” (lines 27-28). The “of course” indicates that this is a common assumption with which we are all familiar and which therefore requires no further elaboration.

When referring to the client’s suicide attempt and subsequent anorexia, the use of the words “had” and “went” (lines 30-31) construct both suicide and anorexia as external events over which the client has no control. He does not make a suicide attempt – he “has” one; then he “just” (line 31) goes into AN – he does not make a decision to stop eating. The implication is that the client is a victim of his “queer” (line 29) sexuality who lacks the agency to prevent his decline into self-starvation, without fundamentally altering his physicality by increasing the level of male hormones pumping through his body. The similarity between Therapist C’s two clients then is that in the first case, a male saves the client and in the second the client needs to save
himself by increasing his maleness. Masculinity is therefore constructed as being the key to overcoming anorexia.

Overview

In an interview-style DA study, only a small percentage of data can be presented for analysis. Unlike quantitative studies where the aim is to make generalisations across populations, the aim of this research is to examine the discursive resources drawn upon and the subject positions taken up by individual therapists in their talk about AN. According to Harper (1994), such examinations are an important means of establishing links between ideological critiques and ‘discussions with real practitioners’ (p.151). This paper has found such links between the ideological claims of Burman (1997), Lurie (1990), Malson (1998, 1999), Malson and Ussher (1997) and Parker (1997, 1999) and the psychotherapeutic discourses drawn upon by the ‘real practitioners’ interviewed in this study. It has been noted within these critiques that dominant cultural ideologies are reproduced in psychological theories and in the practices that evolve from them. The current research has provided several illustrations of the reproduction of these ideologies within therapists’ talk about AN and, in particular, those related to the mother-blame discourses of psychoanalysis and the romantic discourses of patriarchy. The repertoires drawn upon by the therapists reported here were, in the main, typical of those drawn upon by the therapists interviewed.

In their discourses about AN, Therapists A and B constructed the female-to-female relationship of mother and daughter as deeply pathological. The predominance of psychoanalytic repertoires was evident, possibly because this model offers a discursive resource for the explanation of AN whereas other models, including CBT, do not. Amongst the psychoanalytic repertoires was that of mother blame, which was drawn upon in Therapists A and B’s talk about AN. Mother blame is a common discursive resource used in the explanation of children’s bad behaviour (Burman, 1997) and it was invoked as an explanation for poor therapeutic outcome in this study. Both Therapists A and B positioned themselves as having the right and responsibility to intervene in the mother/child dyad, for the sake of relieving the child of her ‘illness’. Parker (1999) notes that ‘bad’ mothers are commonly blamed for the
problem of their children's 'madness' and that psychotherapy offers 'to pass as a solution' (p9). This research illustrated how accounts of 'bad mothers' were constructed, together with therapists' positioning of themselves as a healing resource.

In their conversations about mothers, Therapists A and B also constructed them as denying their daughters the agency to develop as persons in their own rights. Both the fairytale and the psychodynamic repertoires employed by therapists in their narratives about AN are widely culturally available. A noteworthy aspect of fairytales is the construction of older women as envious of the youth of young women, who are depicted as passive, beautiful and more sexually desirable than they are (Lurie, 1990). Within this discourse, older women are constructed as attempting to prevent younger women from becoming sexually mature and entering into a heterosexual relationship. Although therapists did not draw upon a fairytale repertoire to describe the mother/daughter relationship in this way, there is a structural similarity between psychoanalytic constructions of mothers and those of fairytales. In both constructions, older women attempt to deny the agency of burgeoning adolescents.

Therapist C did draw upon a fairytale repertoire in order to describe a client whose therapy she constructed as successful. Again, the fairytale framework had resonances with psychodynamic theory, which postulates that psychological fulfilment is possible only through the maintenance of a heterosexual relationship. Malson (1998) and Malson and Ussher (1997) argue that romantic discourses locate women within particular patriarchal power-relations and that these encourage harmful practices of body management, like anorexia. Therapist C demonstrated that romantic narratives are located within therapeutic discourses of recovery, suggesting that psychotherapeutic discourses help to maintain these damaging practices. In addition to drawing upon fairytale and psychoanalytic repertoires, therapists interwove professional discourses into their conversations in order to warrant their claims about their experiences of AN clients. Underlying all of these constructions is a culturally ascribed power dynamic that weighs heavily in the favour of therapeutic practitioners, placing greater value on their 'professional' opinions (Parker et al., 1995). It might therefore be concluded that what AN clients and their families have to say about
themselves, their anorexia and, in particular, about their therapeutic experience is afforded comparatively little social value.

[Personal Overview]

The reflections in this section may depart from a strictly social constructionist epistemology. However, within the institutional context of the university where my training is being taken, they may contribute to understandings of the research process.

In order to conduct the study, I made choices about the research topic, data selection, the method of analysis and, perhaps most importantly, about the specific interpretations to be placed upon the text. All of these choices were inevitably informed by my critical, deconstructionist stance toward the theories and practices of psychotherapy. The subject of eating disorders, so closely linked to cultural assumptions about women and the regulation of their bodies, was an area of interest I developed whilst still an undergraduate studying both psychology and women's studies. However, at the time of these studies I was not also a psychotherapeutic practitioner, located within a mental health structure, as I am now. The greatest dilemmas I faced in conducting this research were connected to my identification with the mental health profession and with the discipline of critical psychology. The tensions between the two respective positions left me struggling with many aspects of the study and produced questions like: to what extent should I assume an informed stance in relation to the theories espoused during the interviews?; had I influenced the interviews in ways that might not be readily apparent?; and will my criticisms appear to reflect badly upon the individual practitioners who were good enough to offer their valuable time to be interviewed?

To a degree, I could resolve dilemmas of diversity in locations because I am not an essentialist who anticipates experiencing a consistent and coherent 'self'. Rather, I expect to shift my subject positions according to the discursive practices of the situated contexts in which I am placed or choose to be. Also, my criticisms of psychotherapeutic practice are never directed at individuals, only at the technologies, as Foucault refers to them, that regulate their practices. The aim, of course, is to unsettle and impact upon the discourses that prevail amongst the psychotherapeutic
community and not to assail individual practitioners. Nonetheless, it was disconcerting at times to isolate certain texts generated by certain therapists for the purpose of maintaining a critical stance. Perhaps this was especially difficult as I knew four of the interviewees and had met two others within a variety of professional contexts, where I was always their less experienced subordinate.

Just as I do not take an approach that isolates pathology within the individual, I also do not perceive individual therapists as being culpable for assuming the social practices and beliefs of the culture they were born into and are hence, as Parker (1992) argues, not of their own choosing. My view is that they draw upon the professional discourses available to them and that are expected and often required of them. As a person who also works within these contexts, I too am called upon to reproduce the psychotherapeutic discourses made available to me. This does not diminish the importance I place upon making the criticisms that I have made in this work. We need to know what we are doing when we say things to, and about, our clients and their families, however professionally painful that might be. To be critical is not to 'throw the baby out with the bathwater' and condemn all psychotherapeutic endeavours as well-meaning but hopelessly wrong-footed and irretrievably destructive. Rather, it is to scrutinize and make transparent the scaffold of values and ideologies that structures our theories and we should do that with, at least, the same efficiency and rigour that we utilize in the investigation of our clients' difficulties. After all, if we can place our client's lives under the spotlight of intense examination, then surely we can accommodate some critical enquiry into our own professional platforms and agendas. To do this from a purely theoretical perspective is not enough. We must first discover the precise attitudes and ideologies that are reproduced within therapeutic narratives and this requires the analysis of individual therapists' discourses. As for those therapists whose words came under the sharp focus of this analysis, I can only hope that they will appreciate the necessity of this methodology and its contribution to psychological understanding. My own means of trying to resolve the dilemmas created by taking a critical perspective lie in the searching out of new ways of being within my therapeutic practice. Hence for instance, the development of the notion of the 'dialogic unconscious' (Billig, 1997), which modifies both social constructionist and psychoanalytic approaches. (See the research
References


Walstrom, M. (2000). Starvation... is who I am: From eating disorder to recovering identities through narrative co-construction in an internet support group. Humanities and Social Sciences, 60(12A), 42-49.


List of Appendices

Appendix A – Ethical Approval Letter

Appendix B – Consent Form

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Appendix E – Interview Schedule

Appendix F – Transcription Conventions
Dear Ms Diamond

**Eating their words: A discourse analytic study of therapists' accounts of Anorexia Nervosa (ACE/2001/98/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 and the following condition is met:-

- That the first part of the title, i.e. 'Eating their words' is removed, as it is felt that this may be considered inappropriate.

For your information, and future reference, the 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/2001/98/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.

Contd ....
I should be grateful if you would confirm in writing your acceptance of the condition above, forwarding the amended document for the Committee's records.

Date of approval by the Advisory Committee on Ethics: 11 January 2002
Date of expiry of approval by the Advisory Committee on Ethics: 10 January 2007

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

CONSENT FORM

PARTICIPANT’S COPY

I fully agree to take part in this study into therapists’ accounts of Anorexia Nervosa and I give my consent for the researcher to use the interview material as data for the study. I also give my consent for the interview to be audio taped and I understand that the audiotape will be destroyed following the completion of the research. I understand that segments of the interview may be contained within the research report but that neither I, nor my clients, will be identified in the study.

I am fully aware that I can withdraw from the study at any time without providing reasons or justification and that my withdrawal will be completely without prejudice.

Name of Participant
(BLOCK CAPITALS)  
Signed  
Dated

Name of Researcher
(BLOCK CAPITALS)  
Signed  
Dated
Appendix C

DEMOGRAPHIC INFORMATION

Please complete the following questionnaire, which will be presented in a generalised form within the research report.

Age:

Gender:

Ethnicity:
(Please circle)
Black-African
Chinese
Indian/Pakistani/Bangladeshi
Black-Caribbean
White
Black-Other
Other:
(Please specify)

Number of Years in Practice:

Highest Educational Qualification:

Theoretical Orientation:

Therapeutic Setting in Which Your Work is Conducted:

Occupation/Job Title:
Interviewer: Um I wondered (..) how you came to be interested in working with eating
disorders and particularly in anorexia(.)

Therapist B: (...) well what happened was when I was completing my MSc one of the
tutors came in and asked if there was anybody who would be interested in doing a
placement or working with people with eating disorders and I agreed (.) I found it
interesting so I went along and started a placement in eating disorders (.) I then
traced it back to many years before when I had actually done a project with young
people who were overweight (.) and I had done some of the same reading and talked
about working with them and their weight issues (.) but that is the only connection
really(.)

Interviewer: So you so you had an interest, but it was quite a tenuous (.)

Therapist B: very tenuous(.) interest yes

Interviewer: um (.) OK(.) and so obviously when you finished doing the MSc
though you (.) it was an interest that was still there because you carried on

Therapist B: NO I started it as I was finishing the MSc

Interviewer: I see (.) it was offered to you as a post

Therapist B: no it was offered to me as a placement (..) if I didn’t because I had
time free (.) and do you want me to tell you how it developed and what I ended up
DO:ing

Interviewer: yeah yeah

Therapist B: (...) well it was a placement at at (name of hospital) which used to be the
in-patient unit where I was working with the consultant who was actually working
primarily with bulimics (.) he then um he then phoned me one day and asked me if I
could do a locum for him in the out-patient clinic as a bulimia therapist in this ten
week programme I did that and then (...) there were two two people doing it and I
did a locum (.) for one person and then (...) I can’t remember exactly how it went
now (.) the other person resigned so I applied for her post and got it

Interviewer: right right

Therapist B and uh (...) then I worked for three and a half years I was employed then
and we got the occasional anorexic (inaudible) an anorexic who was also bingeing and
vomiting and then I went to work in the (name of hospital) I was working a lot with
anorexics there and then I left the (name of hospital) after two years and people
here
find me or get referred through my uh circle or my network of eating disorders (.) but
also people come to see me or have come to see me who don’t acknowledge that they
have got an eating disorder or (..) they find me (.) I don’t know how (laughing) but
they creep in here
Interviewer: right (.) so so you have got experience of working um within the NHS
and privately with eating disorders and I am interested particularly in anorexia um
(...) can you say a little bit about the differences (...)
Therapist B: between anorexia and (...) or about the settings (...)
Interviewer: about the settings yes how you find working in various settings(.
Therapist B: um well I prefer my practice because in my practice I can set the time I
can set the parameters it is longer term (...) anorexics you work with them for years
years and you don’t necessarily have that option in in the NHS(,) I know about the in-
patient treatment for anorexics more than I do about the out-patient (...) in the NHS
but I suppose that is partly (.) my PHIL:osophy is that as a result of the work that I
have done and the consultant that I have worked with (.) I feel that the food issue has
got to be ad addressed or else there is no point working(.
Interviewer: right so how how do you see your role then in the treatment do you see
yourself your role as getting weight up or working on other issues or a lot of those
things are there PARTS of it you would pass on to other professionals (...) how do
you see that
Therapist B: I was just thinking of the last three that I have worked with (...) one has
been very much about (...) she is a bingeing anorexic and it was about containment (.
with her and um SH:she (...) as she worked, she became willing (...) she got herself
referred to a psychiatrist(,) she doesn’t live in this area so she couldn’t go to (name of
hospital) (.) she got herself referred to a psychiatrist and a dietician but they said that
they did no insight work I would have to continue working with her(,) and yu you
know we had no contact (.) she reported to me what she was doing with the others and
now she very very seldom abuses the food and we have really got to the other issues(.
another one had done the out-patient programme and so the bottom line was the food
my assumption was you are eating food(,) (laughing) the other one and the third one I
have finally got her to keep a diary and realised how little she was eating and so
slowly I said (...) I laid down a boundary and said you have I can’t continue working
with you unless you go to a psychiatrist and I told her(,) there were all sorts of other
things that I wanted her to do (...) very much I set the agenda(.) so my feeling is
always that the food needs to be dealt with and with that last one it is still very much a
threesome(.) she sees the psychiatrist she sees the nutritionist and I am now part of a
team(.) rather than an individual therapist in private practice(.)
Interviewer: um so so yes so you see yourself (...) um well I suppose there are two
things I thought about whilst you were speaking(.) one of them was that um you may
take different roles with different clients and the other is that even if you are taking
different roles you would still(.) be part of a part of a team(.)
It depends how severe the eating disorder is (...)
Interviewer: right, ok
Therapist B: like the first person I didn’t feel it was life-threatening because it wasn’t
as severe(.) this one it is a real abstaining anorexic and I wasn’t prepared to take that
risk(.) not that she would DIE or kill herself(.) she wasn’t that anorexic(.) but I
wasn’t prepared to collude with the half life that she was leading(.) because she
would muck about with her diet (laughing) instead of dealing with the feelings bottom
line
Interviewer: right(.) so in a way for you it is a way of letting someone else deal with
an aspect that (...) of of the disorder that um (...) doesn’t really utilise your (...) what
you have to offer
Therapist B: well when I was working at both of the (names of hospitals) we
combined(.) we did everything(.) the first thing a person did was they got weighed(.)
I weighed them as they walked in the room recorded the weight and then we showed
them the DIARY and we talked through the diary and then we would talk about other
issues(.) so there we did the whole (...) contained the whole lot(.) in the beginning
talked more about the foo:ood and less about the feelings and later on talked more
about the feelings(.) not the food
Interviewer: so is that something that you would work towards as well in private
practice
Therapist B: no because I only deal with food and I don’t weigh the person(.) I
would do a diary(.) as a way of getting information
Interviewer: uh hum(.) so I wondered then how you see the various sorts of models
fitting together in treatment(.) so for instance you may be seeing somebody who:oo
would be referred as well to a psychiatrist and and he would give a particular type of
Treatment (.) do you see that as conflicting with the treatment you are giving (.) well obviously you don’t (.) but I suppose what I am asking is about your orientation and how you see that in terms of the other models

Therapist B (…) well I feel that any work with an eating disorder has to (.) well usually does contain a behavioural element(,) eating is a behaviour and that is part of why I like to let that part go to somebody else (,) although I will say that the dietician and I especially this one that I am dealing with right now (,) the dietician and I talk every week (,) so I know what her weight is (,) and so I challenge her on her weight and what is she holding back and what she is doing to OUR relationship by not staying at her target weight and not eating the food (..) in terms of orientation I am always (…) I’m always listening to what is going on in the transference (,) I am integrative as far as training but I very much listen to what is going on in the transference (,) I think developmentally um (…) I the influences my influences (,) theoretical influences have been Hilda Brusch (,) do you know Hilda Brusch

Interviewer: yes I do

Therapist B: and I have heard quite a bit of Suzie Orbach

Interviewer: they are quite different

Therapist B: they are they are and Suzie Orbach probably less but I don’t know if you have come across a book it is now out of print called body self and psychological selves by Kruger

Interviewer: I have seen it yes actually

Therapist B: well I just think it is wonderful and there has been some reading in self psychology which I think of and then (…)

Interviewer: Kohut

Kohut (,) it is in an eating disorders book

Interviewer: right ok

Therapist B: self psychology approach to working with anorexics (,) so all of that informs my need from a theoretical point of view(,) I ALSO have a supervisor who has worked a great deal on eating disorders (,)

Interviewer: do you have a VIEW about what causes anorexia

Therapist B: for me anorexia (…) I am treading a little bit on thin ice here because I know that (name of colleague) doesn’t go along with this developmental model but for
Therapist B: well she talks about symbiosis up until about nine months the child is symbiotically merged with the mother and then separates and individuates and spends the next well first of all it isn’t very enthusiastic about separation and individuation and then is AM:bivalent and comes back and doesn’t want either one and then goes on and develops I feel that anorexics merge (inaudible) separation and individuation they remain somehow still merged with the mother and don’t have a keep doing this because (..) in my Gestalt training this was merger there is no boundary there is no self-delineation

Interviewer: that merger happens

Therapist B: well they never separate as infants and so they stay merged with the the mother but I also feel that it has to do with the infant’s needs being ignored and the mother’s needs being need being imposed on the infant the feeding takes place at definite times when the mother decides not when the child the infant decides

ALSO THINK THAT most psychosomatic disorders (...) I like to think that psychosomatic disorders are caused because the young infantchild doesn’t develop a language to express internal feelings so they express it through their bodies instead and anorexia is a consequence I’m starving I’ve got to make myself smaller because of the impinging overwhelming kind of (inaudible) all the metaphors about greed and I get bigger and I can’t fill myself and I can’t have my new life so that informs me I don’t know (laughing)I’ve gone off on one of my favourite theories

Interviewer: I wonder then about how you think of anorexia historically that if you feel it is the motherchild relationship and there seem to be now so many women developing eating disorders and in fact when I spoke to (name of colleague) she said that 80% of women have a sub-clinical eating

Therapist B: [somebody quoted that to me today yes]

Interviewer: did they because I haven’t heard it before
Therapist B: yes a sub-clinical eating disorder (.) it is all tied up with body image and
how for me (…) I mean if we talk about the developmental model but if you take a
societal one or a cultural one why is it Western women and Israeli women who have
eating disorders (.) they don’t have eating disorders in other parts of the world (.) it is
like the further they come up the economic scale then people develop eating disorders
(.) Naomi Wolfe um about women being controlled and their way of being controlled
is to keep thin because then they just think about their feelings and they are so
emotional and that sort of thing so is that part of it (.) patriarchy (…) is this what you
want to be hearing from me

Interviewer: yeh

Therapist B: (laughing) alright (.) historically women started becoming emancipated
after the First World War so the ideal woman was thin (.) flappers aa:and the advent
of feminism in the 70s and women began to look thinner and thinner and younger and
younger (.) of course in this (intake of breath) all the fasting saints (.) and the seeing
visions and also the depriving body (.) surviving on the minimum (.) there has been a
constant (…) I remember (name of prominent eating disorders psychiatrist) used to
always talk that there has always been sort of a constant number (.) a constant
percentage of women who have been anorexic over the ages (.) ten years ago I was
hearing him say that the incidence of anorexia has not gone up (.) but BUT you’ve
got to believe that a lot of the young women that I see around and about are
ANOREXIC or partly sub-clinical anorexia and they don’t consider it anorexia (.)
they consider it as what they have to do for their jobs or to be attractive or like the
societal demands (.)

Interviewer: so I suppose I was thinking about more men being diagnosed with
anorexia now (.) uh uh what view would you take on that (.) why it might be more
men might be developing anorexia now (.)

Therapist B: well there are demands on men’s bodies (.) I was reading we got a FREE
magazine today with one of our magazines and it was on fashion and I went through
and there was (…) looking at the men and the same pressure on men to look beautiful
(.) I actually spent some time recently talking to a young male model and was asking
him about his lifestyle and (.) how long he had been in the profession and about what
he needed to do to MAIN:tain himself (.) he said that the average career is four years
(.) he had been in it for eight which was unusual (.) you were asking me specifically
with anorexia (.) but I know that there are a lot of um athletes (.) types of athletes who
are bulimic (.) rowers lightweight rowers particularly (.) jockeys (.) boxers (.) because
they all have to keep a weight (.) if they are down with their weight they do whatever
it is and then they stuff themselves

Interviewer: so are you saying that when men develop anorexia or bulimia it is a
reaction to having to (...)

Therapist B: it is more an out there kind of thing (.) whereas I feel with women it is
an inside (...) it is a more internal conversation (.) men (.) young girls (.) young
women have eating disorders or or or muck about with food and young men muck
about with alcohol as a big generalisation

Interviewer: I wondered if given that we are talking about changes in who is
presenting with eating disorders (.) whether your attitude has changed about eating
disorders (.) I mean you have worked with anorexia for quite a long time has your
view of it changed from when you first started working with it

Therapist B: (...) um um my conceptualisation of it hasn’t (...) probably hasn’t
changed very much (.) that is because of my way of thinking when I am working with
a client (...) one of the things about anorexia (.) working with anorexia is that I now
can fit (...) I am very aware of how it is yes it is a separate entity but at the same time
it fits into a definition of a borderline personality disorder (.) maybe not a disorder but
in that kind of (..)

Interviewer: so are you saying that from the time you started you have begun to see
more borderline features in people with anorexia

Therapist B: well (...) it is like anorexia to me used to be a separate entity but now it is
no longer as much (.) it is a category

Interviewer: right so are you saying then that there is more co-morbidity than you
first (.) thought about

Therapist B: perhaps (.) that is one of the things (...) I am wondering whether I am
thinking about my bulimics rather than my anorexics (.) in terms of (.) but one in
particular has got very borderline characteristics (.) it is PARTLY (...) also what has
changed for me is I have been (...) I am always quite optimistic as the therapist (.) I
think you have to be but I have become aware of THE STRUGGLE of working with
anorexia (.) so that I have got to the point where I would say I am not going to be
involved with this struggle anymore (.) no more treating people with eating disorders
Interviewer: so you feel that working with eating disorders is very demanding of you as the therapist

Therapist B: OOHH yes yes

Interviewer: can you say a little bit about why that might be

Therapist B: they are hard work they are hard work

Interviewer: harder than other

Therapist B: oh yes oh yes (.) one of the big revelations I have had WAS with one client I mentioned earlier and I said I felt that they had to see a psychiatrist and I finally said alright NO MORE no more (.) you know two more appointments a month apart and then we’re finished kind of thing (.) she went to a psychiatrist and the psychiatrist recommended in-patient treatment (.) she wasn’t going to do it she wasn’t going to do it so I said alright we’re finishing then because it was actually going into I continued working with her through her in-patient stay but was going into the hospital and attending the ward round the part about HER and feeling the containment of being a member of the team really struck me because working here I don’t have that (.) it is part of the reason (.) it is like I by insisting that the treatment continues with the three of us I keep that containment for myself as well as for my client (.) it also breaks the merger between her and me because she then knows that I talk to the others and she is not included so therefore I have to be a separate person

Interviewer: SO what you are then implying is that the problems of merger with mother are then translated elsewhere like here particularly

Therapist B: yes

Interviewer: so in some ways what you seem to be saying is that it is the difficulty of working with that particular type of patient that has led you to maybe look elsewhere (.) but it is very demanding (.) particularly demanding work

Therapist B: yes and it is (...) for MYSELF I really appreciated the containment and the very boundARIED position that the team help in hospital

Interviewer: was it the shared responsibility

Therapist B: it was a shared responsibility but it was also how they could just sit there in silence and let (...) the way the ward round goes is that everybody puts in their opinion and the psychiatrist writes down the points that he has to emphasise (.) the patient comes in HE delivers the team’s COMBINED wisdom

Interviewer: reflections
Therapist B: reflections to the client (.) so she can’t split and therefore it was
important for me to be there (.) another thing about the containment is that is a
hospital where they all go to work and go home (.) I see my clients here (.) sometimes
they see my DOG sometimes it doesn’t happen very often but my husband’s study is
BELOW they hear the music they hear the rumble of his voice if he is on the
telephone they hear banging (.) they phone me (.) do I answer the phone do I not
answer the phone (.) could it be a client could it not be a client (.) so there is a
possibility for intrusion into my space which doesn’t happen to them
Interviewer: and you are also saying that the intrusion does give away sometimes (.)
that they can hear your husband or see your dog and I suppose I wondered about that
(.) Do you see that as an intrusion (.) do you see that as AS not a good thing
Therapist B: well it depends on the CLIENT and I suppose (.)
Interviewer: something you can’t control
Therapist B: yes but also with this kind of client I feel that they want to possess me
for themselves (.) now I will talk about what it is like to hear the noise or whatever but
I am then asked (.) particularly with this type of client (.) I get asked all these personal
questions about my life and of course I nod (.) not always but I do try and divert it
Interviewer: I wonder if you can give an example of say a particularly difficult client
in the sense of wanting you to merge (.) I mean obviously I am aware that you have to
be mindful of confidentiality and change details and things (.) but I wondered if you
could give an example of a client that was maybe particularly difficult in that sense
Therapist B: as you said then I suddenly thought OH MY HEAVENS (.) what about
this person I’ve been talking about the hospital about and I assumed that I could trust
your confidentiality in terms of the details
Interviewer: [of course yes]
Therapist B: so I suppose I am talking really honestly to you (.) if I can make that
clear
Interviewer: well if you change the details somewhat and then I will change them
again (.) when I do the transcript I change the details as well
Therapist B: an example of how the client felt merged with me or
Interviewer: I suppose a client that you felt was particularly difficult particularly
difficult for you
Therapist B: ok there’s the one who brings me presents of food
Interviewer: and that is difficult because

Therapist B: because I (...) first of all I feel uncomfortable accepting presents (...) I am happy to accept a little something when they are finishing but one who walks in at every celebration with FOOD for me you know packaged food (...) the last time I headed it off by saying we’re coming up to Christmas again don’t bring this (inaudible) it is yours (...) this went on for two or three weeks and then finally I said on the last one before Christmas I said you can bring it but you are I will eat equal parts of it and you will take whatever is left home with you and that (...) she was (...) that was ok in terms of the merger (...) I have just been away on holiday how come I didn’t send a postcard I could have sent a postcard

Interviewer: right so it sounds as if some of the difficulty is maybe a sense that you get from a client is that you can’t give enough (...) however much you give it is not going to be enough

Therapist B: it is not (...) it is not just how much I give isn’t going to be enough (...) she tells me she wants to move in with me she wants to move in

Interviewer: (laughing) that’s fairly intrusive

Therapist B: her fantasy is that I’ll bring her to live with me yes (...)

Interviewer: so I suppose what I am wondering about this is in terms of the success of the therapy that (...) do you feel that this merger is something you are working on in the therapy do you feel it makes the therapy less successful or

Therapist B: I am not quite sure what you mean by your question

Interviewer: I suppose I am making the assumption (...) I was making the assumption that a difficult client might be one whose therapy wasn’t (...) you didn’t feel was successful but I may actually be wrong with that

Therapist B: Well, I think that the difficult client is the one who resists me and fights because then I have to fight – I have to fight part of them for the other part. So the way I have been looking at it recently has been that the wanting to get better part of her she projects into ME and then attacks me or fights me, rather than HER talking about these two parts of herself or how many parts there are, but rather than her holding her wanting to get better and my being able to work with that in her. It is like I GET IT. This is something I have only recently become aware of with this particular client. Of course, therefore I end up exhausted.
Interviewer: mm mm yes mm (.) I wondered if you could give an example of successful therapy, where you felt it had worked really well and (..)
Therapist B: [laughs] when I was working with somebody recently who (.) who:oo was (...) got a got a TWO ONE finished, completed her course, knew what it was she wanted to be DO:OING (coughs) and had moved into a flat with people she liked and respected her who appreciated her boundaries.
Interviewer: uh:hh
Therapist B: uhh. (...) then I really felt and was able to keep her mother or her FEELINGS about her relationship with her HER MOTHER when they met again and the same old thing happened she was able to realise that it was her mother’s (…)
Interviewer: uh.
Therapist B: uhh. (...) I just hoped underneath the food was ok
Interviewer: mm. Mm (.) so the success was in the way she was able to carry on
Therapist B: her life, rather than someone else’s life
Interviewer: right (.) uh huh because that is something you have been particularly talking about um and I suppose then it makes sense in terms of the merger that she was able to (.) to move away from that symbiotic relationship with you and develop
Therapist B: WELL she didn’t become symbiotic with me
Interviewer: uh huh
Therapist B: sh:she and I developed a more maybe she did in the beginning but she resisted it (.) she and I were always able to work (.) yes in the transference there was always well she really trusted me but she trusted me (laughs) she was a little bit separate she didn’t become the (...) LI:M:pet that this other anorexic I just talked about feels like leech
Interviewer: mm mm
Therapist B: (..) sometimes I feel that she is a leech and then I am losing my (.) life blood.
Interviewer: sort of a host
Therapist B: yes
Interviewer: for her to feed off mm mm (…)
Therapist B: this is interesting it is like I am (laughing) doing some supervision while I am talking to you
Interviewer: well I have to say that all of these interviews I have done have been like this wonderful (inaudible) for me (...) they have been absolutely brilliant (...) I feel like I get a double benefit

Therapist B: I don’t know how (name of colleague) works with children with eating disorders (...) anyway that is just on the side (...) I don’t know how she does it but anyway (...) Interviewer: I wondered why (...) I mean you said earlier that you feel that there is this symbiotic relationship from infancy (...) why do you think it presents at adolescence usually

Therapist B: because they go through the same thing again in adolescence (...) it is not a symbiotic relationship but usually the job (...) the task of adolescence the way I see it is to separate from the family of origin and go off and do whatever (...) but to separate and that is (...) to me that is where the struggle is (...) so that is where the ambivalence is (...) can I go out and become my own person and the anorexic stays at home (...) not always but if you look at the anorexic girl the woman turns herself into a girl (...) the soft hair and the loss of the sexual characteristics and the drive to be out in the world and to be going from (...) Eric Erickson talks about going from the LAT;ency period to the more (inaudible) (...) going from the latency period into identity and then into intimacy (...) alone (...) you know women (laughing) fortunately go a completely different way (...) to me to a certain extent an anorexic avoids growing up (...) by keeping her body small (...) but I also think that it is about fear of death (...) that by not growing up they don’t have to knowledge that they are going to die (...)

Interviewer: do you think that there is anything particularly that brings about that kind of dynamic

Therapist B: I haven’t really thought about it often I HAVEN’T thought about what brings it about (...) but I do think one of my clients I feel that (...) I certainly find that when I go away when we have a break I die for her or I am dead for her because I am not available (...) it is not that I am away or that I am not available for a while (...) it is like I am dead

Interviewer: so if you’re not there you don’t exist

Therapist B: you don’t exist yes (...) it is interesting because we have been talking a lot about this (...) about life and there was a bit from Yalom I am a Yalom enthusiast for his well known (...) the meaning of life (...) when he actually talks about how how
people who have fully lived life are more able to accept their death (...) it is difficult
for the people who have only partially lived their lives. Death becomes a much
more frightening prospect. To me sometimes I think of anorexia as a way of
avoiding ageing and death.

Interviewer: yes right so you take in that sense an existential view.

Therapist B: yes. That is another (laughing) another way of thinking about it. Yes.

Another way of conceptualising it.
Appendix E

Interview Schedule

1) How did you come to be interested in working with anorexia? The client group, job availability etc?

2) Is this a client group that you would like to continue to work with?

3) How demanding of you, as a therapist, do you feel this particular work is?

4) Are you interested in one type of treatment or do you use a combination?

5) Do you feel your work is different than working in other areas of therapy, with a different clientele? (Prompt: How so? or what ties these therapies together?)

6) Why do you feel that adolescents frequently present with the symptoms of anorexia? (Also depending on response to first question)

7) Have your views of anorexia changed over the period of time that you have been working with this client group?

8) How do you feel that your interventions make a difference to the lives of those with anorexia? In what ways? With ‘good’ clients or ‘difficult’ clients? Can you give me an example of successful therapy? of unsuccessful therapy?

9) Why is it, do you think, that more women than men suffer from it?

10) There are anecdotal reports that the numbers of males diagnosed with anorexia are rising. Why do you think that might be?

11) How do you see your role in the treatment of anorexia? (Prompts: are you concerned with making a diagnosis or managing symptom control or maybe more concerned with understanding the underlying issues or even all of these things?)
12) Do you feel that the different models of treatment can work together to help the AN sufferer? (Prompt: CBT treatments with psychodynamic treatments with family therapy treatments with interpersonal therapy treatments - depending on therapist’s approach.) How so? Can you give me an example?
Appendix F

Transcription Symbols:

CAPITAL LETTERS: emphasis

Underlined words: louder speech

[square brackets]: overlapping speech

(.) a short pause

(1.0) a timed pause
How Rude Can You Get?
The Dialogic Unconscious in Therapy

The dialogic unconscious is a concept proposed by Billig (1997a, 1999) that links the seemingly oppositional domains of discursive psychology and psychoanalytic theory. It employs the Freudian notion of repression to explain why certain utterances are privileged over others and it suggests that discursive acts have repressive as well as expressive functions. Billig (1997a, 1999) believes that the temptation to be rude is so often and so routinely repressed that an unconscious rhetorical skill occasioned by the social requirements of everyday conversation is developed to facilitate this repression.

In order to examine the utility of the concept of the dialogic unconscious this study subjected transcripts of six psychodynamic therapy sessions from two clients to discourse analysis. The sessions were examined for instances of clients' talk about politeness in mundane conversations and for evidence of discursive repressions. Conversations concerning repression were implicated in clients' conceptualisations of their perceived psychological difficulties. A number of discursive practices used for the accomplishment of repression were noted. The functioning of a dialogic unconscious was observed in therapy and implications for discourse analysis and psychotherapy are discussed.
How Rude Can You Get?
The Dialogic Unconscious in Therapy

A few years ago, the components of two apparently oppositional psychological schools were brought together by Billig (1997a) in the notion of the 'dialogic unconscious'. The dialogic unconscious links the diverse and seemingly oppositional approaches of discursive psychology and psychoanalysis, following connections also made by Holloway (1989), Parker (1997) and Sayers (1990) among others. Billig (1997a) asserts that the Freudian notion of repression can be conceptualised as a dialogical achievement and, like all such linguistic acts, that it is both socially constituted and that it has social consequences. Freud (1924) considered his discovery of repression to be the single most important insight he made regarding psychological functioning. He suggested that repression occurs when thoughts, ideas or impulses are not allowed into conscious awareness because they would be a source of anxiety or distress. Described as the 'cornerstone' of his work (A. Freud, 1981), the concept of repression continues to influence not only psychoanalytic practice but also the entire field of psychodynamic theory. Billig (1997a, 1999) has connected dynamic psychotherapies with discourse analysis by proposing that discursive acts have repressive as well as expressive functions. He suggests that conversational participants, actors or interlocutors are often unaware that certain topics of conversation or areas of discussion are being repressed.

Billig (1997a, 1999) adopts a discursive psychology approach which usually constrains discussion of constructs of the mind - like the unconscious - preferring to concentrate on explanations of behaviour that are based on speech acts, for example apportioning blame, offering excuses and warranting a particular speaking position. Psychoanalysis, on the other hand, relies on constructs of the mind to account for psychological functioning. Billig contends that the gap between the two theories can be bridged in such a way that the psychoanalytic concept of the unconscious can be usefully employed to account for what discursive psychology has so far left unexplained: how actors suppress or eliminate certain utterances or topics from conversation without being aware that they are doing so. In other words, he explains how discursive repressions are able to accomplish social acts. The unconscious act of
repression is believed to be created in rhetorical process as a means of socially avoiding particular subjects, accounts, speaking positions or acknowledgements.

On a macro level, discourse analysis (DA) can be used to examine how language mediates the broad relationship between people and their cultures (e.g. Parker, 1992; Willig, 1999) and this approach relies on a Foucauldian rationale. Discourse analysis, as practised by discursive psychologists, brings together ethnomethodology, semiotics and conversational analysis to underpin theoretically the practice of examining the occasioned nature and action orientation of speech in order to discover how social conventions are accomplished (e.g. Antaki, 1994; Bergmann, 1992; Billig, 1997b; Dickerson, 1996; Pomerantz, 1978, 1980). Garfinkel (1967) was particularly concerned with the practice of conversational morality, or what he termed 'practical morality' and he noted that politeness was essential to the maintenance of conversation even when there is disagreement amongst actors. Conversational flow is facilitated by the uttering of polite words or phrases such as 'yes' or 'uh huh' to denote agreement or that the listener is attending to the speaker's speech (Grice, 1975). This attention to politeness is also referred to as 'everyday morality'. If repression can be said to be the cornerstone of psychoanalysis, then everyday morality might be described as the cornerstone of social discourse. Billig (1997a, 1999) suggests that where a moral utterance is occasioned, the immoral temptation to rudeness needs to be suppressed.

How is this accomplished? According to Billig (1997a, 1999) the desire to be rude is so often and so routinely repressed that it arises spontaneously and unnoticed, in other words unconsciously, alongside everyday conversational dialogue. The dialogic unconscious is therefore comprised of utterances 'which could well have been spoken, but which remain unspoken' (Billig, 1997a: 141). In essence they are temptations that have been unconsciously avoided. Coyle (2000) notes that it is the DA researcher's primary task to provide a coherent account of the way in which speech acts perform specific social functions. The dialogic unconscious attempts to explain why certain utterances are privileged over others and it thereby addresses a gap in the theory and practice of this approach, according to Billig (1997a, 2000). He notes that discourse analysts are not normally concerned with utterances that remain unspoken.
Clearly, the DA approach favours analysis of the externally observable process of interaction in talk over explanations that rely on the study of inner processes to account for social phenomena. Psychological states and emotions are viewed as being rhetorically constituted and accomplished in the action of talk. In this way, DA can be seen as oppositional to traditional psychoanalytic principles that suggest early childhood experiences - often pre-lingual ones posited to be incidental to the act of speaking - are fundamental to later adult perceptions of reality. Freud’s theory of the mind, of what is conscious and what remains unconscious, suggests that material which is too troubling to the conscious mind is repressed. Additionally, the very act of repression must itself remain unconscious and it is therefore also repressed. But in psychoanalytic theory there is a gap in the theoretical explanation of repression, as it fails to account for the way in which repressive mechanisms operate in order to become unconscious. Billig argues, ‘We have to create our unconscious. Unless we do something - unless we repress or push aside thoughts - we won’t have an unconscious’ (1999:17). He therefore believes that the unconscious is created when thoughts are not expressed either outwardly in our conversations with others or internally as part of our inner rhetoric.

Freudian theory postulates that the hidden or secret desires of the child begin with the Oedipal Complex and that undesirable wishes or impulses are repressed from conscious thought. Billig (1999) argues that the focus on Oedipal characteristics should shift from children to their parents because it is most often they who acquaint their children with normative social practices. He believes that, through dialogic exchange with ‘Oedipal Parents’, the child learns what is acceptable behaviour and what is considered to be rude or immoral. Adults therefore express their anxieties regarding immoral practices to their child in the form of admonishments and punishments for bad behaviour and particularly for unacceptable utterances. Effectively, the adult teaches the child everyday morality (Shotter, 2001a) and they do so often by abandoning the use of everyday morality in their conversations with the child (Aronsson, 1991).

From a Freudian perspective, the central task of psychodynamic therapy lies in uncovering what has been repressed and bringing this into the conscious awareness of
the client (Freud, 1938). The client is believed to respond in therapy according to a pattern of behaviour established in relationship prototypes learned in early childhood. However, the client is said to be unaware that they have developed these relationship structures and, often because of childhood trauma, they are believed to repress the knowledge of their own defensive functioning. In a similar sense, Billig (1997a, 1999) proposes a developmental mechanism in the dialogic unconscious. He suggests that repression is learned and then becomes an unconscious process. Although Billig is an academic and not an analytic practitioner, he does raise questions of whether and how dialogic understanding of repression might facilitate psychotherapeutic practice.

It is the aim of this research to examine the utility of the concept of the dialogic unconscious and its possible implications for discourse analysis and psychodynamic therapy. More specifically, the research aims to study therapeutic conversations concerned with dialogic repression and to examine how these repressions are managed in talk. Several questions will be addressed in the course of this analysis. Do issues of dialogic repression surface in therapy and are these repressions problematic for the clients? What rhetorical strategies are used to achieve dialogic repression? Can the functioning of the dialogic unconscious be observed in conversation and how might this contribute to the theories of discourse analysis and psychotherapy?

Method

Participants

Transcripts of six psychodynamic therapy sessions were obtained from a pre-existing library held by the Psychological Therapies Research Centre (PTRC) at the University of Leeds. The selection of sessions was randomly made and three sessions from each of two clients were analysed. The PTRC is an organisation that was developed specifically for the purpose of studying psychological therapies and all clients attending the Centre are aware that the therapy they receive may be used for research purposes. The clients provide written consent to the PTRC for this purpose and they are advised that they can withdraw their consent at any time.

Both of the clients whose material is used in this study attended 16 sessions of therapy. Client A was a married woman in her mid-30s and this was her first
experience of therapy. Her therapist was male. Therapy sessions seven, ten and eleven were used in this research. Client B was a married male in his mid-50s who was a previous user of mental health services. His therapist was female. The data for this study are taken from his fourth, fifth and eleventh therapy sessions. Both clients had been diagnosed with a ‘depressive illness’ by their GPs. Therapists had been trained in the use of Hobson’s Conversational Model of Interpersonal Therapy (Margison & Shapiro, 1986).

**Procedure**

Ethical approval was obtained from the University of Surrey’s Advisory Committee on Ethics (see Appendix A). All six therapy sessions were audio taped and transcribed by the PTRC using transcription conventions suggested by Jefferson (1978) and modified by Atkinson and Heritage (1984) (Appendix B). The transcripts were anonymised in order to protect the confidentiality of the clients. Initially, several readings of the data were made in order to select conversations that might broadly relate to utterances concerned with everyday morality. These early readings monitored the text for instances of clients’ concerns about repressed dialogues which included talk about possible avenues of discourse either closed off to clients or closed off by them. Repression was defined as the individual or collaborative avoidance of utterances pertaining to certain themes, accounts or questions that were accomplished in routines of talk and of which the speaker appeared to be unaware. Conversations were divided into two broad areas: mundane conversations occurring in social relationships outside of the therapeutic setting and those that occurred between the client and the therapist. More detailed examinations were made of these passages in order to extrapolate any recurrent discursive patterns and themes were identified from these patterns. Working hypotheses were then formulated about the discursive practices of repression and the implications this may have for discourse analytic or psychotherapeutic practice. The final selection of extracts was made on the basis of their representation of the data set and of the discursive practices identified in these preliminary investigations.
Analytic Approach

Billig’s (1997a, 1999) concept of the dialogic unconscious arose from the epistemological framework of discursive psychology and DA is the analytic method normally employed for associated research. It will therefore be utilised in this study. The discursive psychology approach developed and advocated by Edwards (1997), Edwards et al. (1992) and Potter and Wetherell (1987) is normally reserved for the explication of expressive speech acts which focus on concerns of conversational footing, speaking positions and entitlement. Departing from this restrictive interpretation of DA, Billig’s version permits inferences to be drawn about what might be repressed and the discursive means by which this is done. Billig (1996, 1997b) has developed a rhetorical approach to the analysis of discourse, which is concerned with argumentation and persuasion. This approach examines the taken-for-granted ideologies of religious practice and ‘banal’ nationalism (see Billig, 1999 and 1995, respectively), for instance. Billig’s (1997a) approach to DA suggests that a detailed examination of the conversational interchanges between interlocutors should be made and that attention should be paid to the particular occasion and context of specific utterances. It is Billig’s discursive psychology version of discourse analysis that which will be used in the present study.

Evaluation of the Research

Yardley (2000) suggests that four criteria are appropriate to the evaluation of qualitative research, including discourse analytic work. They are sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. It is her belief that rhetorical persuasiveness and the impact and utility of research are critical features of any psychological work and should be evaluated to determine the importance of a study to the body of knowledge. Because the current work challenges some of the conventional notions of two established schools of psychology - discourse analysis and psychoanalysis - it may be that the persuasiveness of the research and the evaluation of its utility will be particularly useful means of assessing the contribution to psychological studies. Modifications being made to the approaches of both discursive psychology and psychodynamic theory might unsettle the assumptions of the advocates and practitioners of these respective ideological
schools and therefore arguments supporting the notion of the dialogic unconscious may need to be particularly persuasive in order to overcome theoretical objections.

**Analysis**

One passage from each of the two clients will be considered in turn, beginning with Client A. In the first extract, the following conversation occurs between Client A and her therapist during her tenth psychotherapy session. Prior to this discussion, Client A had explained to the therapist that her mother had had a miscarriage when she was aged nine. She continued to describe her own feelings about having children and the impact that her mother's miscarriage may have had on her subsequent interest in children, and particularly, in young infants. In this extract the letter 'Q' refers to Client A’s husband.

**Client A: Extract 1, Session 10**

1 Therapist: (11) And that really comes about with Q
2 Client: [mm mm]
3 Therapist: when Q is...
4 Client: Because he's the one I've opened up to more. My Mum did ask me why I was asking about this baby business. But it's just like my granddad was, and I had to talk to my Dad. It was something I was really confused about. I knew it had happened but I couldn't quite put two and two together and...I mean I've been like..I've wanted to know for years, I was just..never asked. She said "Oh, why did you want to know?" I said, "I can't remember" She said, "Well you were there", and my Mum couldn't understand. She said, "I honestly thought," she said, "You never talked about it because you were upset about it." And I said "Honestly I can't remember." And I really cannot remember. (Inaudible). I want to remember now, but...
5 Therapist: You want to remember it?
6 Client: Mm. I feel as though it's important that I remember it, but I've racked my brains and I...

Much of this segment is reported speech, a common feature of everyday talk. According to Wertsch (2001), when a past conversation is reported in subsequent speech, interlocutors are attempting to maintain the integrity and authenticity of the
dialogue by separating the reported voices. Client A separates her voice from that of her mother’s in a distinct and consistent manner and this may be done to support the speaking position she has adopted in her conversation with the therapist, possibly as a means of warranting her assertion that she cannot remember details of the miscarriage: ‘I knew it had happened but I couldn’t quite put two and two together’ (lines 6-7). Bakhtin (1981), who also wrote under the name Volosinov (1986), describes how the invocation of another’s voice acts a rhetorical strategy to support the claims of the reporter. Client A is fending off any challenge or suggestion from her therapist that she might be able to recall details of the event. Her mother has already challenged this, ‘Well you were there’ (line 9), and therefore Client A pre-empts any similar doubt that might be expressed by her therapist.

Client A also suggests that there has been familial confusion about what is said to whom and why. Both of her parents and her grandfather are mentioned by the client, ‘My Mum did ask me why I was asking about this baby business. But it’s just like my granddad was, and I had to talk to my Dad’ (lines 4-6). Client A is therefore attending to the conveyance of this sense of confusion to the therapist and she reports the conversation in order to fend off possible challenges by her therapist to the presented scenario that she has forgotten the circumstances of her mother’s miscarriage. She warrants her loss of memory by not only telling her therapist about it but by reporting her conversation with her mother, ‘And I said “Honesty I can’t remember.” And I really cannot remember,’ (lines 11-12).

In her conversation with the therapist, the client warrants her account of memory loss in several ways and it is to this construction that many discourse analytic readings would be most likely to attend. The psychoanalytic literature, on the other hand, might be more concerned with other aspects of the therapeutic interchange. One of these might be disavowal. A psychoanalytic reading of the passage might speculate that the client’s mother’s assumption was correct and that she had never raised the subject of the miscarriage because it was distressing, (lines 10-11): ‘She said, “I honestly thought, she said, You never talked about it because you were upset about it”. That the client acknowledges she ‘knew it had happened’ (lines 6) might be taken as evidence of this. In all likelihood, a psychoanalytic reading would assume that the reported
conversation had actually occurred and further interaction between the therapist and client would therefore focus upon the events as they are reported to have unfolded.

Whilst being mindful that both of these analysis might provide an alternative reading of the dialogue, the dialogic unconscious is concerned with those speech acts which surface, unnoticed, in the conversation. Because it is not in the nature of the unconscious to be fully evident, it is likely that interlocutors will be attending to other speech acts when instances of the dialogic unconscious arise. Hence, Client A might be concerned with an explanation of her loss of memory while simultaneously providing clues as to how repressed dialogues are achieved. Billig (1999) argues that when repressed themes creep into reported narratives, ‘this should give more, rather than less, confidence in pointing to the possibility that dialogic repression may be unwittingly practised in conversation’ (p125). For interlocutors, the objective of reporting other conversations is to accomplish a specific social aim - they are constructing an account of what has been said by someone else in order to warrant their own speaking position - and not to illustrate what is unconsciously avoided. Billig (1999) advocates the examination of the ‘little words’ in order to uncover what might be repressed in talk. Therefore, examining the fine detail of this conversation may point up instances of the practice of such repressions within the client’s dialogue.

This extract begins after a significant pause of 11 seconds, which often indicates that the conversation has reached a transitionally relevant place (Goodwin, 1984). Silences of one second or longer in mundane conversations pose problems for conversational interlocutors, according to Jefferson (1989). Longer silences in therapeutic settings are tolerated, says Sacks (1989), as a means of indicating that in therapy the client can have their say. It is possible that in the long silence of 11 seconds, Client A was having some difficulty in formulating a statement because she was unsure of how she would be heard by the therapist. Shotter (2001a, 2001b) suggests that parents provide their children with a dialogic model of social discourse. Billig (1997a, 1999) too believes that parental rhetoric influences the way that dialogic acts will be practised by the child. ‘Oedipal parents’, as Billig refers to them, may make certain areas of discussion problematic even when there is no apparent reason for dialogic reluctance. If talk about the miscarriage was discouraged, or even
prohibited, in mundane conversation at home, then it is possible that there was also some difficulty for the client in raising the subject elsewhere. It may be that the 11-second pause and the problematic moment that followed it occurred because the client experienced the subject matter as socially awkward. This possibility seems all the more likely as the analysis continues to focus on the fine detail of the client’s specific utterances.

Following the pause, the first spoken clue that suggests some difficulty in conversing about the miscarriage is provided very early on in the conversation. The miscarriage is euphemistically referred to as ‘this baby business’ (line 5). What is significant to the notion of the dialogic unconscious is not a fact-based interpretation of whether the client’s mother used the actual words being reported or even whether or not the conversation between the client and her mother actually happened. What are of interest are the words used by the client in the present to make her point to the therapist. Why, in her conversation with the therapist, does Client A refer to the miscarriage as ‘this baby business’ and not as ‘my mother’s miscarriage’ or even as ‘the baby’s death’ as she might have done? It could be that to speak more directly about the death of an infant or a foetus might be construed by the client as rude or as contravening some social, moral code about this topic, even within the therapeutic setting. The loss of the unborn child may be such a delicate matter amongst her family that Client A can speak of it only in the very vaguest and most imprecise of terms when she is conversing with her family. It is also possible that this message has been socially reinforced outside of the home environment so that no direct or specific mention can be made about this event inside or outside of the family without raising some moral dilemma about how the information will be heard and thus whether or not it should be presented at all.

According to Silverman (2001) when potentially delicate items are discussed, particularly in a therapeutic context, expressive caution is exercised. The expressive caution used by the client in this segment additionally marks out the subject of her mother’s miscarriage as a delicate or awkward one for her, (lines 7-8): ‘I mean I’ve been like...I’ve wanted to know for years, I was just...never asked’. Several conversational repairs are made during the course of the client’s explanation and the
client begins the sentence with ‘I mean’, which is a conversational device that also marks out expressive caution. When such markings occur they carry strong implications for the moral characters of those both in and under discussion (Silverman, 2001). If, as Silverman (2001) suggests, moral characters are at stake when expressive caution is used, it is possible that Client A’s remarks were related to implications about either her own or her mother’s moral standings.

The client may be accounting to the therapist for what could seem to either or both of them as an inexplicable failure on the part of the client, to pursue a subject, the miscarriage, which she has suggested is of deep and enduring interest, ‘I’ve wanted to know for years, I was just...never asked’ (lines 7-8). At no time does the client say ‘I couldn’t ask’ or ‘I wasn’t allowed to speak about it’. It may therefore be that everyday morality prohibits the acknowledgement that certain subjects are barred from conversation and therefore there is a need to repress the suggestion that these topics are being repressed. Not only should one not speak about particular subjects but possibly, conventions of everyday morality require that the very act of dialogic repression should itself be repressed. After all, if forbidden topics were openly acknowledged as forbidden then questions might be asked about the wisdom or benefit of this repression. The silenced material would then be brought into the realm of the socially acknowledged and hence, defeat the primary object of repressing the subject.

Client A’s claim that she ‘was just...never asked’ (line 8), is also a way of fending off a possible allegation by the therapist that her mother should have spoken to her daughter about what had happened much earlier in the client’s life. The conduct of significant others normally has implications about one’s own moral conduct, according to Silverman (2001). So, it may be that the client was attending to the moral implications of her statements as concerns her mother’s failure to explain the events under discussion and her own failure to broach the subject sooner. The client’s loss of memory satisfactorily explains both why she knew nothing about the circumstances of the loss of her mother’s baby and why there would now be a need for her mother to provide details of the occurrence. By invoking a memory loss, Client A is constructing a version of events that she cannot explain or elaborate and which
therefore closes down further investigations of who was responsible for her lack of knowledge.

Edwards and Middleton (1986) and Edwards et al. (1992) have written extensively about the social accomplishments of remembering and forgetting, arguing that memories are constructed by conversational participants for social purposes. During the course of this passage, Client A problematises her inability to recall what happened at the time of her mother’s miscarriage and she constructs a reason - her loss of memory - for her interest. What seems pertinent to explorations of the dialogic unconscious is that an unwitting participant in dialogic repression, one who may be unaware that a particular topic is being resisted, might construct alternative accounts of conversations, which are in some way unconsciously constrained. Perhaps this is particularly appropriate to studies of claims of forgetting because memory loss does appear to provide a plausible explanation for the failure of a speaker to pursue specific areas of conversation.

Additionally, according to her report, the client needs to account to her mother for her need to know about the miscarriage. Again, whether or not the client’s mother actually asked her why she wanted to know about ‘this baby business’ is not the focus of this analysis. Of primary concern are the hidden assumptions contained within the client’s report of her conversation with her mother. By accounting to the therapist for her need to know about the loss of this baby, (line 14): ‘I feel as though it’s important that I remember it’, the client is assuming that she needs to provide an explanation for her interest in this area, or that such an explanation is morally requisite. Therefore, this may not be a matter the client feels able to discuss without offering a reason for her interest. The wish to talk about the miscarriage is subsequently said to have been dismissed by the client’s mother as being somehow unnecessary because the client was there when the miscarriage happened. But why should this be? The client follows with an explanation. She provides a report of her mother’s response to her curiosity, (lines 10-11): ‘She said, “I honestly thought”, she said, “You never talked about it because you were upset about it.” By reporting this comment, the client is assuming a tacit understanding between herself and the therapist that one should not broach a subject if it stirs up painful emotions. It seems likely then, that dialogic
repressions are accomplished by putting an emotional spin on the topics of conversation that an interlocutor wishes to close down or make unavailable to others.

Client A’s mother is said to have believed that the client had not mentioned the miscarriage because she had been upset by it. This statement is additionally of interest as it provides several alternative insights into the ways in which dialogic repression can be interpreted. First, as already described, it speaks of a tacit understanding that if a matter is ‘upsetting’ then it should not be discussed. The implication is that Client A’s mother is attending to the conventions of everyday morality by avoiding the subject as a means of protecting her daughter from becoming distressed. Second, it preserves the Client’s mother’s moral integrity, and consequently the client’s integrity, as it accounts to the therapist for why she had not spoken sooner about the matter to her daughter. It implies that the client’s mother had an awareness that the subject was not being talked about and that she might even have expected that the subject would be raised had her daughter not been upset. This constitutes a denial of her mother’s interest in repressing the subject of the miscarriage and it therefore confirms what has been previously suggested about dialogic repression - that the conventions of everyday morality require a denial that a subject might be unmentionable or off-limits.

Client A has illustrated that dialogic repression might slip into therapeutic conversations even when the client is unaware that certain topics of conversation have been closed off to them. A number of rhetorical manoeuvres are involved in the accomplishment of this repression. Euphemisms mark out the subject as being delicate and a more elaborate vocabulary may be drawn upon in order to avoid specific utterances. When interlocutors are unaware that dialogue is being repressed, they may privilege versions of dialogic accessibility - in this instance invoking memory loss to account for conversational reluctance. The doing of dialogic repression seems to carry moral implications for the actor and also for others being discussed and therefore explanations about why these barriers might be imposed appear to be required of speakers. This may produce a denial that a topic is being resisted or it may lead to claims that the interlocutor is attending to the emotional needs of others by not raising the subject. Dialogical barriers initiated in the home
could be presumed to carry social prohibitions elsewhere and speakers may therefore exercise rhetorical restraint in other contexts.

**Client B: Extract 2, Session 5**

The following extract occurs in the first few minutes of Client B’s fifth session. He begins the session by talking about the holiday he has just returned from and the subsequent feeling of dread he had upon returning to work. Apart from an initial greeting and one ‘Mm hm’ token (Czyzewski, 1995), the therapist has said nothing for several minutes while the client talks. This segment occurs about two-thirds of the way into Client B’s dialogue.

1  Client: And er it's...it's very worrying because I feel it's wrong that I should be paid for
doing a job when I'm I can't get enthusiastic about it. I'm just I'm just working every
day without well working without enthusiasm, as they say. Um, and this troubles me
a lot but I don't know what to do about it. Um (4) I feel I ought to try and if I'm in
meetings or anything, I ought to try and impress myself on on other people what I've
got to say, but it comes out so weakly these days as I... I just er I had a bit of a a set
to in a bit of a meeting today because of just an argument about a..the way we were
looking at something. And I was sure I was right and the other person was sure he
was right, and he was entirely wrong the way that I was looking at it, and it seemed so
tiring and exasperating to me because it's all quite pointless arguing about these
things, doesn't get anybody anywhere. And yet each person has to stick to
their..(laughs) their guns and er to try and justify what their that they are right.
Everybody seems to do this. I do it myself. And yet so much time is wasted by this
futile argument that doesn't get anywhere. Um and yet I feel if I don't try and impress
myself on somebody else they just ignore me altogether, so I might as well not be
there. (sighs) And er the other thing is I seem to get..even now I've been away on
holiday I should be invigorated, but when I'm at work I'm anything but. And I I find
that my voice, I feel as though there's a constriction in my throat and my voice gets
weaker and weaker and I'm talking like that. And that's gives you a lack of
confidence when that happens, so I just tend to shut up and that's it.
Throughout this passage, Client B talks about the way that he speaks to other people and the way that others speak to him. A key feature of this therapeutic talk is the client's sense of dialogical self-repression and the constraint of possible speech acts during conversational interaction. A conventional discourse analytic reading of this text might draw upon positioning theory and focus upon the client's subject position. According to Davies and Harré (2001) positions are learned through lived and narrated texts and people are often unaware of the position/s to which they have ascribed. This type of reading might speculate that Client B appears to be unable to negotiate alternative rhetorical positions in such a way that he regards his utterances as being heard, acknowledged and of sufficient interest to others to warrant their attention. Instead, he believes conversation to be a dialogic game and the assumption is, unless he plays along, he will disappear, and that he 'might as well not be there' (line 16).

That the client has adopted this rhetorical position is of less interest to studies of the dialogic unconscious than are the possibly 'unconscious' speech acts, which might serve to maintain and perpetuate such a position. The notion of the dialogic conscious attempts to examine the client’s narrative in order to point up not only what subject positions are taken up but how they are taken up. A close reading of this extract shows that the client's sense is that he has no choice but to engage in this conversational game from which he will inevitably emerge as the loser with no one but himself to blame. He may repress particular utterances because he is unaware of how to perform specific rhetorical tasks: 'it's all quite pointless arguing about these things, doesn't get anybody anywhere' (lines 10-11).

The voice that is recognised and legitimated by others is a voice born of an uneasy rhetorical combat and it is a voice that is forced, according to Client B's account. He claims that the effect of this perceived discursive failure is that he is dialogically constrained: his sense is of being both determined by it and trapped by it. There is an inferential link made in his words suggesting that he could do and say more but that this would be socially unallowable and he would therefore be ignored: 'they just ignore me altogether, so I might as well not be there' (lines 15-16). Although we do not know what Client B might say were his other voices to be heard, it is clear from
this passage that dialogic repression is presented as a central concern in his conceptualisation of his problems.

Further analysis of the client’s talk indicates that Client B’s self-repression is not a rhetorical strategy wittingly selected in order to accomplish desired social acts. Despite Client B’s claim that he has adopted a speaking position that is problematic, he seems unaware that alternative positions are available to him. However, he reports that they are open to others, ‘I feel as though there’s a constriction in my throat and my voice gets weaker and weaker and I’m talking like that. And that’s..gives you a lack of confidence when that happens’ (lines 18-20). The question here is not of whether Client B actually does become physically unable to speak. Rather, it is his apparent sense of being caught in a world that disallows him to respond in a way that he might consider to be more appropriate.

It seems likely that Client B’s response has been learned and is now replicated in a way that is automatic yet disturbing to him. The effects of self-repression seem to be unwanted by the client, whose responses to dialogic challenge arise spontaneously, according to his account. It might be speculated that this dialogic manner has been developed through habitual practice and has come to be performed unconsciously. The client’s claim that, ‘I don’t know what to do about it’ (line 4) are echoed by a dialogic manner which appears to prohibit criticism of others, ‘Everybody seems to do this. I do it myself. And yet so much time is wasted by this futile argument that doesn’t get anywhere’ (lines 13-14). The client suggests that he would like to make his point with others and to impress himself on his colleagues whilst at the same time acknowledging that his efforts are futile, ‘they just ignore me altogether’ (line 15). Despite his sense of being ignored, Client B refrains from blaming others for his rhetorical inadequacies, as he perceives them to be.

At the beginning of the extract Client B offers a moral account and assessment of himself at work. Immediately prior to this, he said that he had lost interest in his job and therefore line 1 might be seen as a way of fending off the criticism that he is morally irresponsible or ignorant. He is asserting to his therapist that he is not the sort of person who takes money for doing a poor job and he therefore fends off criticisms
concerning his status as an ethical employee. Although he has warded off these possible accusations, he also constrains self-criticism. This is so much the case that Client B is unable to say directly what he appears to be implying - that he might not be doing his job properly, ‘doing a job when I’m...I can’t get enthusiastic about it’ (line 2). He makes a second attempt to be more specific about what he is doing, or not doing, at work but his utterances are replete with problematic formulations and there is another hesitation before he repeats that he is working ‘without enthusiasm’ (line 3). He completes the sentence with ‘as they say’, in order to downgrade his utterance. This seems to be a problematic topic for Client B and, in common with Client A, he appears to use words that are imprecise and vague as a means of avoiding dialogic specificity. In other words, he seems to be doing self-repression as he speaks of it.

Generally, speakers show strong preferences for descriptions of events that offer routine, and normalised versions of what might be unusual or significant events (Sacks, 1992). Client B provides such a normalised account of events at work. He has had an argument with a colleague, but he considerably minimises what occurred between them: ‘I just er...I had a bit of a...a set to in a bit of a meeting’ and this was ‘just an argument’ (lines 6-7). There are three hesitations, indicating possible unease about how his utterances will be heard by the therapist. There are also four downgrades in his statement (see Silverman, 2001) as ‘just’ and ‘a bit’ are each said twice and thus the illocutionary force of the reported interchange is significantly diminished. This is presented as a routine occurrence with a routine outcome wherein the client is left in a no-man’s-land of rhetorical achievement.

Inferences can be drawn about the client’s sense that he usually loses his arguments: ‘it comes out so weakly these days’ (line 6). Client B is talking about an uncomfortable dialogue at work and he is clearly uncomfortable in relating the story. Yet, the client has brought the topic into the open. Conventional discursive readings might suggest that he has adopted this subject position in order to warrant his previous claim that he is ‘well working without enthusiasm’ (line 3). However, perhaps the client has entered this difficult dialogic territory because self-repression is a recurrent pattern of rhetorical interaction that he would like to alter, but he feels that he lacks the skills to do so. It is possible that, in therapy, clients expose the difficulties they
have in negotiating routine speaking positions because they wish to alter these habitual but restrictive and constraining conversational practices.

The client offers a binary presentation of social linguistic engagement (lines 8-9) when he presents himself and his colleague as being ‘sure he was right’ or else ‘entirely wrong’ in establishing conversational credibility. For the client, these arguments are ‘tiring’, ‘exasperating’, ‘pointless’, ‘futile’, ‘time is wasted’ and he twice repeats that it ‘doesn’t get anybody anywhere’ (lines 10-14). Yet, this is apparently something that everyone does and he does it himself (line 13). This extreme case formulation, in which everyone, even he is included, functions as a means of accepting blame and responsibility for his assumed conversational weaknesses. He is also taking on the mantle of failure rather than blaming his colleagues for his inability to speak with greater illocutionary force. This indicates that conventions of everyday morality prohibit blaming others for one’s perceived rhetorical inadequacies. It also suggests that there are strong norms which prevent blame for conversational repression being shifted away from one’s self. It shows that repression is accomplished through the reproduction of socially accepted conversational norms and customs that prohibit the claim that speech acts are being closed off or disallowed. This was also shown in the case of Client A whose memory loss was invoked to account for the dialogic repression she encountered.

Some features were common to the analysis of both Clients A and B. In their therapeutic conversations, both spoke in some detail about dialogic repression. This repression was implicated in their perceptions of their respective psychological difficulties. Rather than speaking specifically about a topic she wished to raise, Client A used imprecise and vague terms when discussing it. Client B employed this practice when he too appeared to want to speak about certain topics. Also familiar to the analysis of extracts from these clients was that strong norms seemed to be in place that prohibited accusing others of dialogic repression. Client B appeared to habitually practice dialogic self-repression. He reported being accustomed to it as a routine form of conversational interaction and he repressed his speech when talking to his therapist. For Client B, his dissatisfaction with the ways that he rhetorically positioned himself in mundane conversations was a subject of therapeutic talk. Additionally, the client
accepted responsibility for his assumed conversational inadequacies, as everyday morality prohibits the blaming of others for one's perceived discursive failures.

**Overview**

This study presents an analysis of a limited selection of material from the pool of available data. One of the potential criticisms of the dialogic unconscious framework is that, as in all such analyses, multiple readings are possible. Inevitably, the readings made here will differ from those that might be suggested by other discourse analysts (Coyle, 2000). For instance, it may be that Client A reports the conversation between herself and her mother to her therapist as a means of warranting her claim that her mother did actually have a miscarriage. Additionally, it may be that Client A uses the phrase “this baby business” because she is maintaining the thread of a previous conversation about babies and not because she is more comfortable using a euphemistic term. This reading seemed less likely to me however, because the client had unlimited rhetorical scope to introduce both the topic of the miscarriage and the topic of babies without employing one phrase to suggest the other.

In the case of Client B, it could be argued that throughout his conversation with his therapist, he is not uncomfortable in relating his narrative of dialogic failure but that he is attempting to elicit a preferred response from him. It could be speculated that rules of politeness dictate that the therapist should contradict the client’s claims of conversational ineptitude and therefore that the client is inviting a more positive reflection about himself from the therapist. However, because the customs and rituals of therapeutic conversation do not always coincide with those of mundane conversations, I did not adopt this reading of the text. It seemed much more plausible that Client B’s claims were made in the context of the therapeutic setting specifically because they would invite a response that acknowledged and accepted his difficulties. However, these readings may present some challenges to discursive psychologists and also to psychotherapeutic practitioners, as the assumptions on which the research is based requires modifications to the theoretical perspectives of both traditions.

In addition, it could be argued that the analysis of therapeutic transcripts is hampered by the two-dimensional nature of the texts, which are devoid of any non-
verbal information. However, in their conversation analytic work Goodwin and Goodwin (1986) and Schlegloff (1984) have found that non-verbal behaviour is guided by, and auxiliary to, what is being done verbally. In other words, non-verbal behaviour normally accords with what is being said. A number of conclusions can be drawn from this work, which might be incorporated into the bodies of knowledge informing the respective practices of discourse analysis and psychotherapy.

In answer to the research question: 'Do issues of dialogic repression surface in therapy and are these repressions problematic for the clients?' - one of the most predominant discourses of these therapy sessions concerned clients experiences of dialogic repression. Talk in which repression emerged as an issue for the clients took several forms and was reported to occur in a variety of contexts. Clients A and B reported experiencing discursive repression as an ongoing process and this repression in talk arose as an important factor in their perceived psychological difficulties. Yet, neither client offered any explanation as to how or why repression was socially occasioned and accomplished. On the contrary, dialogic repression was experienced as an everyday occurrence and, to that extent, was taken for granted as an accepted and unnoticed collaborative discursive practice. It was the clients' own management of repressed dialogue that was problematised, especially by themselves, in therapy. This was particularly so in the case of Client B whose discursive functioning was reported to be inadequate in his own eyes.

In answer to the second research question, 'What rhetorical strategies are used to achieve dialogic repression?', several were identified. Vague and imprecise terms, including euphemisms, were used to avoid making specific utterances and opening up particular conversational avenues. Partial conversational shifts occurred and utterances peripheral to the subject were made. Because interlocutors were unaware that dialogue was being socially repressed, they privileged versions of dialogic accessibility, and memory loss was used to account for enquiries into a specific subject. The doing of dialogic repression appeared to carry moral implications for the actor and explanations were required for imposing dialogic barriers. This lead to the denial that a subject was being repressed and to claims being made that repressions were for the benefit of others. Clients took responsibility for their assumed discursive
failures, indicating that everyday morality prohibits the blaming of others for perceived rhetorical shortcomings. Dialogical barriers initiated in the home could be presumed to carry social prohibitions elsewhere, with the result that speakers exercise rhetorical restraint in other contexts.

The final research question pertained to the observation of the dialogic unconscious in therapeutic conversation and the ways in which this study might contribute to the theories of discourse analysis and psychotherapy. This research illustrated that particular themes, accounts and questions were avoided in the routines of talk and that clients seemed unaware that this occurred as a collaborative process. It also showed that where there are partial conversational shifts, this indicates that there is resistance to particular utterances. The ways in which clients discussed conversational repressions supports the view that repression is practiced habitually and that it is therefore a consequence of the functioning of a dialogic unconscious. The dialogic unconscious is a concept that could be adopted and utilised by discourse analysts in their investigations into those areas of conversation that are closed off from discussion. To date, apart from Billig's (1997a, 1999) work, research has been concerned mainly with the expressive functions of speech acts. Although there have been some studies concerning notable absences in conversation, these have been mainly confined to the avoidance of accepting certain subject positions— for instances, by not answering a specific question (see Boyle, 2000; Clayman, 1993). However, it is not enough for DA practitioners to acknowledge that certain areas are not taken up in conversation without investigating the social implications of such discursive practices. The findings of this study help to clarify the rhetorical markers of repression, and hence show the operation of the dialogic unconscious in action. Investigating these rhetorical strategies would enhance understanding of repression in talk.

Other areas of this analysis can enrich psychodynamic theory and practice. Talk about discursive repressions was a notable feature of psychotherapy and it is important that therapists should be made aware that clients find these repressions problematic and would like to change them. It should also be of interest to therapists that everyday morality prohibits the blaming of others for repressing certain topics of conversation.
and this also requires attention in therapy. Process notes and recording are commonly used tools for the analysis of clients' sessions and examining process notes for evidence of the ways in which clients claim to be disadvantaged by discursive repressions could facilitate the therapeutic endeavour by opening up alternative dialogues. Studies that examine the detail of parent/child interactions would illustrate how parents teach their children the art of conversational repression and consequently, how the dialogic unconscious is acquired.

[Personal Overview]
It has been more than a year since I wrote this piece of research and therefore the comments provided here are retrospective accounts of my involvement with the work. Also, I have written extensively in this Portfolio about how the dialogic unconscious has affected my clinical practice (The Dialogic Unconscious: The Missing Link or a Contradiction in Terms?, p.32). I first read about the notion of the dialogic unconscious in 1997 when it was published in the Journal of Social Psychology. At the time I was a second year undergraduate with an interest in both discursive psychology and psychoanalytic practice. The former came about as a result of academic study on the degree course and the latter because of my own experience of psychoanalytic psychotherapy, which I had found immensely helpful. At the time of undertaking the first degree I found the combination of the two disciplines stimulating and exciting but I can't claim to have fully understood the implications of the dialogic unconscious until several years later when I was no longer a recipient but a provider of psychological services.

It cannot have escaped the attention of any reader of this Portfolio that I am critical of much of psychoanalytic theory and practice. So why have I so fully embraced the notion of the dialogic unconscious, especially with it's emphasis on Freudian ideas of repression and the unconscious? To put it simply, Freud was a progressive thinker who, like most of us, held the values and beliefs commensurate with many of the social assumptions of his time. Although he was constrained by those views and assumptions, his contribution to psychology was great and I believe that aspects of the therapeutic relationship he promoted have helped many people. However, he located psychopathology within the individual and not within the macro level social systems
that regulate behaviours. Today, much has been said and written about those social systems and their effect upon the individual, yet we persist in applying a dated Freudian perspective in much of clinical practice. Because it takes a social constructionist perspective, the dialogic unconscious recognises Freud’s positive contribution to psychological theory, together with the effect that social structures can have upon individuals.

The task I undertook in this research - the elaboration of a dialogic unconscious approach to psychotherapeutic conversation - had not been attempted before. This entry into previously unchartered territory made for an oscillating mix of high anxiety and trepidation tempered with exhilaration and excitement. Hearing Billig speak about the dialogic unconscious, as I have done on two occasions, was very encouraging in addition to being a wonderfully pleasurable experience. Billig’s lectures were more a performance than a process of information dissemination and I found his book, *Freudian Repression, Conversation Creating the Unconscious*, to be equally stimulating and captivating. It combines psychological ideologies with historical reconstructions and at times it is reminiscent of a detective novel, unfolding ideas in layer upon layer of newly interpreted evidence until the case is indisputably established. I felt that Billig’s arguments were persuasive enough for me to endeavour to discover whether or not they could have any practical application and I await with anticipation any similar explorations that interested colleagues might attempt. As with any study - but perhaps particularly germane to the Portfolio’s final piece of research - this end point signifies new beginnings and raises afresh the question, ‘Where do I go from here?’.
References


Sociological Inquiry, 50, 186-198.


List of Appendices

Appendix A – Ethical Approval Letter

Appendix B – Transcription Conventions
Dear Ms Diamond

The dialogic unconscious in therapy (ACE/2001/48/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 and the following condition is met:-

- That a specimen copy of the Consent Form, without the clients' signatures, is submitted for the Committee's records to ensure that the original clients consented to further arbitrary access to their 'data'.

For your information, and future reference, the 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/2001/48/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.

I should be grateful if you would confirm in writing your acceptance of the condition above, forwarding the amended document for the Committee's records.

Date of approval by the Advisory Committee on Ethics: 31 August 2001
Date of expiry of approval by the Advisory Committee on Ethics: 30 August 2006

Please inform me when the research has been completed.

Yours sincerely

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

cc: Professor L J King, Chairman, ACE
     Dr A Coyle, Supervisor, Dept of Psychology
Appendix B

(·) – a short pause of less than half a second

(1.0) – a timed pause in seconds

[ ] – overlapping speech

italics – a change in pitch of voice

( ) inaudible