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Power, Relationships and Ethics in Counselling Psychology.

Nicola Margaret Tessa Hart

Submission for award of Doctorate in Counselling Psychology comprising:

Section A: Preface

Section B: Research

Section C: Case Work

Section D: Critical Review of the Literature

Submitted to: City University, London

Registered in: Department of Psychology, City University, London

Supervised by Dr Charles Legg

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‘The most eager speaking at one another does not make a dialogue – for dialogue no sound is necessary, not even a gesture.’

Martin Buber.

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Abstract

Introduction

This portfolio focuses on the issues of power and ethics within relationship in the practice of counselling psychology. The impetus behind the work came from a desire to acknowledge that power is part of all relationships and as the practice of counselling psychology is based on relationship it would be interesting to explore the impact of the power dynamic within three different types of relationship contexts.

The aim of the work is to explore relationships within counselling psychology in terms of power dynamics and consider the ethical issues and challenges that these may raise for counselling psychologists. The portfolio includes an exploration of three types of relationship that counselling psychologists are typically engaged with; the therapeutic relationship with the client, the supervisory relationship with the supervisee and the research relationship with the research participant. Each type of relationship is examined with a view to identifying how power is exercised and perceived and what challenges this raises for counselling psychologists in terms of ethical issues.

Section A: Preface

In the preface I firstly provide a summary of my career history to date and secondly an overview of the other three sections included in the portfolio. It is my aim to show consistency across the areas of my research and their relevance to the profession of counselling psychology.

Section B: Research: An exploration of the dynamics of power within a therapeutic relationship.

Section B comprises a report on a study into the dynamics of power within a therapeutic relationship. The purpose of the study was to identify strategies used within therapeutic discourse to manage the therapeutic relationship with particular reference to the

dynamic of power. The study uses a micro-analytical technique to analyse the interaction between the therapist and client in one twenty minute film clip from a therapy session conducted by Dr Carl Rogers. The conclusions of the study suggest that communication between therapist and client occurs on a number of levels and serves a number of functions. One of these functions is to manage the power dynamic within the relationship. The methodology used in this study proves a useful tool for counselling psychologists to study process aspects of psychotherapy and the theoretical base in critical theory, post-modern philosophy and linguistics offers an additional body of knowledge which may enlighten our understanding of the therapeutic process.

Section C Case work: Reflections on clinical supervision: an analysis of the supervisory relationship with three supervisees.

Section C provides an analysis of three supervisory relationships experienced in my role as a clinical supervisor. This section continues the theme of relationship and explores the way in which counselling psychologists may function as supervisors within their professional context. Although there are many models of supervision within the literature, few of these are specifically relevant to counselling psychology. Supervision is a process with enormous influence in the training of professional therapists and it may be the case that as counselling psychologists we need to consider our responsibilities as supervisors in the development of the profession.

Section D Critical Review of the Literature: Ethical Issues in interview based qualitative research in counselling psychology

Section D concludes the portfolio with a literature review on ethical issues in qualitative research in counselling psychology, again highlighting the importance of relationship. This review focuses on the overlap between research and practice in counselling psychology. As scientist-practitioners counselling psychologists base their practice on research findings and in recent years there has been a growth in the use of qualitative

methodologies within therapeutic research. In particular the qualitative interview has many similarities with a therapeutic interview and much of the literature reviewed presents this as a positive parallel. The review explores the similarities and differences between therapeutic and research relationships and the ethics of fading the boundary between the two.

Section A: Preface

1.0 Introduction

In this preface I will firstly provide a summary of my career history to date and secondly an overview of the other three sections included in the portfolio. It is my aim to show consistency across the areas of my research and their relevance to the profession of counselling psychology.

The boundaries of counselling psychology as a discipline are wide and often fuzzy. They permit an overlap with other related areas of academic and practical expertise which provide the opportunity to develop a depth and richness to the area and discourage narrowness of thought and limited horizons. It is important to be aware of the pitfalls of professionalisation and resist the temptation toward self-aggrandisement and elitism which have suffocated other professions. The area of mental health is very much on the agenda in our current economic climate. Many are searching for solutions and different ways of framing the problems. Counselling psychology, with its roots in a humanistic tradition and its allegiance to a scientist-practitioner model may not be able to provide solutions but may certainly help to focus minds on the relevant questions and perhaps illuminate the issues with a different quality of light. The client-centredness of counselling psychology allows us to maintain a perspective whereby our clients are the centre of the profession. They provide us with problems, solutions, ideas, hopes and fears and ultimately some insight into the human condition. The theory and practice of counselling psychology must aim toward a coherent knowledge base to inform practice which reflects the needs and gifts of our clients as well as ourselves.

This philosophy is reflected in the areas that I have chosen to study for this degree. Firstly, as a humanistic therapist, trained in a person-centred model, I underpin all my work with a basic respect for the individual and have focused my research study on

the work of Carl Rogers himself. My practice as a humanistic therapist is also demonstrated in the case study on supervision. My desire to spread the boundaries of counselling psychology is reflected in the literature base and methodological design of my research study which move beyond the traditional psychological literature into philosophy, linguistics and critical psychology. As a chartered counselling psychologist I believe it important to avoid complacency by adopting a critical stance to my practice, teaching, supervision and writing. There are many areas within counselling psychology where a critical stance may be of benefit and I have chosen the topic of research ethics as my literature review in order to explore one such area. Finally, a practitioner doctorate explicitly requires a relationship between theory and practice and I believe that my research study offers some ideas on the nature of the therapeutic relationship which may be of use to practising counselling psychologists; my overview of the literature on research ethics identifies some dilemmas with which counselling psychologists engaged in research may wish to consider and my case study on supervision provides a reflection on a particular approach to one increasingly important role for the counselling psychologist. Overall, the theme which links the sections of the portfolio is relationships: client-therapist, supervisee-supervisor and therapist-researcher.

2.0 Career History

The three years devoted to studying psychology at an undergraduate level at a traditional university in the 1970s led to my total disillusionment with the discipline in general. I could conceive of nothing relating to the psychology that I had been taught which would provide me with a fulfilling and interesting career. Thus, I registered for an MSc in Sociology which allowed me to move out of the narrow confines of reductionist psychology and consider some interesting issues within a different

paradigm. Again, however, I felt no driving force leading me into a stimulating career. Like many others, I took a teaching job to help pay my debts and keep me going until I decided what to do next. Ten years and two children later I was still teaching when an opportunity arose to become involved in the development of a student counselling service in the college where I worked. To support me in this enterprise I was financed to complete an MA in counselling. The counselling service was born, I reduced my teaching load and increased my counselling role. I began to feel engaged with something meaningful and real but also frustrated with the lack of psychology in my training course and the lack of rigour within the counselling field generally at that time. Eventually on completion of my Masters I moved to a new post in a university as part of a team delivering postgraduate counselling training within a psychology department. It was around this time that I became aware of the growth of counselling psychology within the British Psychological Society and decided that I would try for chartered status as a counselling psychologist. This goal was realised in 1994 and I felt, at last, that I had found a career that allowed me to merge my psychological and counselling training in a way that fitted with my personal values and beliefs. The next few years were devoted to developing the counselling diploma into a Masters in counselling psychology which finally gained BPS accreditation in 1996. In the recent past I have become involved in the work of the Division of Counselling Psychology within the BPS and now have yet another perspective on the development and regulation of the profession.

Currently as a counselling psychologist in an academic position I fulfil the roles of teacher, manager, supervisor, practitioner and researcher. My goals for the future are to take part in the continuing evolution of counselling psychology through conducting and publishing relevant research, developing the training base of counselling psychology

and contributing to the profession through my committee work.

3.0 Overview of Sections in Portfolio

This portfolio comprises, as required by the regulations for the degree of Doctor of Counselling Psychology, the following sections:

- a report on a piece of research conducted into a particular aspect of the counselling psychology discipline,
- a case study based on a particular aspect of my work as a counselling psychologist
- a literature review of a particular area pertinent to the theoretical base of counselling psychology.

Section B comprises a report on a study into the dynamics of power within a therapeutic relationship. The purpose of the study was to identify strategies used within therapeutic discourse to manage the therapeutic relationship with particular reference to the dynamic of power. The study uses a micro-analytical technique to analyse the interaction between the therapist and client in one twenty minute film clip from a therapy session conducted by Dr Carl Rogers. The conclusions of the study suggest that communication between therapist and client occurs on a number of levels and serves a number of functions. One of these functions is to manage the power dynamic within the relationship. The methodology used in this study proves a useful tool for counselling psychologists to study process aspects of psychotherapy and the theoretical base in critical theory, post-modern philosophy and linguistics offers an additional body of knowledge which may enlighten our understanding of the therapeutic process.

Section C provides an analysis of three supervisory relationships experienced in my role as a clinical supervisor. This section continues the theme of relationship and explores the way in which counselling psychologists may function as supervisors within their professional context. Although there are many models of supervision within the

literature, few of these are specifically relevant to counselling psychology. Supervision is a process with enormous influence in the training of professional therapists and it may be the case that as counselling psychologists we need to consider our responsibilities as supervisors in the development of the profession.

Section D concludes the portfolio with a literature review on ethical issues in qualitative research in counselling psychology, again highlighting the importance of relationship. This review focuses on the overlap between research and practice in counselling psychology. As scientist-practitioners counselling psychologists base their practice on research findings and in recent years there has been a growth in the use of qualitative methodologies within therapeutic research. In particular the qualitative interview has many similarities with a therapeutic interview and much of the literature reviewed presents this as a positive parallel. The review explores the similarities and differences between therapeutic and research relationships and the ethics of fading the boundary between the two.

Section B: Research

An exploration of the dynamics of power within a therapeutic relationship.

The irreducible elements of psychotherapy are a therapist, a patient and a regular and reliable time and place. But given these, it is not so easy for two people to meet.

R.D.Laing

Abstract

The notion of power within psychotherapy research has, until recently, focused on the ways in which power is misused within a therapeutic relationship. Inherent within this literature is a value judgement that power is essentially a negative force. The influence of post-modern thought and critical approaches within many disciplines, including psychology, has presented a different conception of power. This research has been particularly influenced by Foucault's notion of power as a force within relationship. The study of therapeutic process has provided much insight into the dynamics of the therapeutic relationship but little attention has been paid to the way that power is used within therapy at the level of the conversational interaction. It is proposed that a dynamic of power exists within the therapeutic relationship just as it does in every other human relationship and this is exercised predominantly through conversation.

The purpose of this study is to identify strategies used within therapeutic discourse to manage the therapeutic relationship with particular reference to the dynamic of power.

This study uses a micro-analytical technique to analyse the interaction between the therapist and client in one twenty-minute film clip from a therapy session. A session conducted by Dr Carl Rogers was chosen as an example of an explicitly 'non-powerful' therapeutic approach.

The results are presented in the form of four separate analyses which identify the

differences between the therapist and client stories and the strategies used by each to exert control over the therapeutic process.

It is concluded that communication between therapist and client can be understood on a number of different levels and ‘therapy talk’ serves a number of functions. Talk may be used to control the relationship itself and the position of the players within the interaction. An analysis of the use of language within therapeutic interactions may illuminate therapist’s understanding of the therapeutic process itself.

1.0 Introduction

1.1 Views on power within therapy

The abuse of power has become an increasing concern over the last ten years in the practise of psychotherapy but the focus has been on misuse of power through financial, sexual or physical means. There has been little written on the way in which values, assumptions and attitudes behind therapeutic theories make the abuse of power more likely. Spinelli (1998) argues that all therapeutic approaches must question how they deal with client need. When considering the evidence on therapeutic effectiveness clients are shown to value the most basic features of the therapeutic relationship such as talking, listening, caring and sharing and see these as the effective components of therapy. So the question is why do professional therapists need to offer theories and complex explanations of the therapeutic experience. Is this mystification a form of defence? Does theory operate as a filter to enable clients' stories to be fitted into a structure that is then operational within a therapeutic paradigm? Butler (1990) argues that psychoanalysis creates the very categories of 'sexuality' and 'desire' that it purports to analyse. The same could be said for any therapeutic approach including the post-modern approaches where discourse analysis replaces the critique of ideology and so changes the terms of the debate. The therapeutic discourse operates within a discursive field firmly boundaried by rules which determine what is a legitimate truth claim and what can and cannot be said. Reality is structured by language in the post-modern world and therefore the influence of rhetoric is much greater in this type of therapy.

Therapists seem able to see themselves as operating outside of the normal influences that affect peoples' behaviour. Lerman claims,

‘Therapists in general believed themselves to be different from other people in that the cultural undertones did not influence them and they therefore were value-free until feminists and members of ethnic minority groups forcibly showed that this was not and could not be true’(Lerman, 1994:91).

Legg (1997) argues that we have no evidence for correspondence between therapeutic narrative and narratives of daily lives. Does what happens in therapy actually impact on the other aspects of clients’ lives or is therapy perceived as something different and outside of every-day life? Turning a ‘blind eye’ to the issue of power in psychotherapy poses a dilemma as described by Laura Brown ,

‘The first location of this dilemma is the failure of the psychotherapeutic relationship, not merely at the symbolic level (e.g.transference) but in terms of the real social and political context forming the matrix in which any given psychotherapy relationship situates itself’(Brown, 1994:276).

She goes on to locate the focus of the power in the role of the therapist and the culture. ‘...that privileges the powerful players in dominance hierarchies” (p. 276). In adopting a medical model the client becomes an object of treatment – a passive receiver of treatment. In this way psychiatry (and psychotherapy?) infantilise the client. The diagnostic labelling process locates the cause of the problem firmly within the individual and in this way ignores, ‘... the unequal distribution of resources and power across social groups ...’ and the way in which this contributes to personal distress (Hare-Mustin & Maracek, 1997). The client believing the problem to be within themselves then empowers the therapist to become the expert in order to treat them without having to address wider social and political causes, ‘Therapists acquire power and responsibility by virtue of being seen by their clients to possess knowledge and skills not available to the uninitiated’ (Legg, 1997: 409).The focus on personal life and self-advancement dominates today’s popular discourse. The popularity of

confessional TV, popular psychology, self-help books and so on demonstrate how self-absorbed we have become. This is an ideal milieu for the nurturing of psychotherapy. Feminist commentators and others have argued, that individualisation exists as a wider scale form of social control and that psychotherapy is an institution eminently suited for its accomplishment (Davis, 1986). This positions psychotherapists in a very powerful position. ‘If therapists are as London (1986) argued and as we have shown empirically, endorsers of a collectively held value system, have they not become arbiters of morality?’ (Jensen & Bergin, 1988:295).

Jensen and Bergin conducted a survey of clinical psychologists, marriage and family therapists, social workers and psychiatrists to assess their values regarding mental health and psychotherapy. The results showed that there was a consensus between mental health professionals that certain basic values are important for mentally healthy lifestyles and therefore a guide for the goals of psychotherapy. These values included being a free agent, having a sense of identity and feelings of worth, being skilled in interpersonal communication, being genuine and honest, having self-control and personal responsibility, being committed to relationships among others, suggesting that these characteristics may form the goals for mental health.

Kathy Davis notes that feminists have criticised therapy at the level of social oppression but not at the level of therapy talk. In her analysis of a therapy session Davies argues that the client’s initial presentation of her problems can be understood as a ‘goodness of fit’ between the client’s situation and her expectations of the situation. However, this is transformed by the therapist into a ‘problem for further therapy work’. It has also been suggested that therapy is a form of social control and dubbed it ‘the power hour’ based on the way that the therapist wields expertise over the client (Green, 1995).

When the issue of power has been addressed in psychotherapy research the focus has tended to be on the elevation of psychotherapy to a position of power in western industrialised society and the way in which therapeutic discourses have become increasingly privileged within this culture (Parker, 1996, 1997). Alternatively the anti-psychiatry arguments of the 1960s have been applied to psychotherapy demonstrating the way in which individual therapists have misused power within the therapeutic relationship itself, (Masson, 1989).

1.2 Approach within this study

The view taken here is different and is characterised by the following propositions,

- Power is inherent to all relationships
- Power is exercised through language
- Power can be productive and is not always negative.

When the therapeutic relationship is understood as a specialised form of relationship which shares some of its characteristics with other types of relationship it allows us to explore the issue of power more directly. The dynamic of power within a therapeutic relationship operates through the process of language. Therapist and client engage in a linguistic interchange which has pre-established rules and boundaries, in post-modernist terms it is a therapeutic discourse. As psychotherapies, independent of approach, tend to be primarily verbal relationships they are all limited by the rules of therapeutic discourse, the limitations of language and of relationship. In fact all therapies are about the use of language in relationship.

The humanistic model of Dr Carl Rogers was chosen as the example to explore further the dynamic of power in therapeutic relationships for a number of reasons,

- It is the approach which claims equality of relationship and client empowerment as its foundations.

- The ideology of humanism is strongly non-authoritarian.
- The therapist occupies a strictly non-directive position
- It is a modernist approach based on the notion of an essentialist self

The critique of the Rogerian model serves to highlight the way in which therapeutic rhetoric makes assumptions which ignore the constraints of language and relationship.

If relationship is understood as a coming together of two individual worlds where understanding must be achieved through language then many therapeutic claims are impossible. Language does not allow us to enter the world of another, it allows us to share a system of agreed meanings and possibly, as post-modernists claim, to construct new meanings through discourse. In attempting to conceptualise this process the work of philosophers and linguists provide a way of understanding the power of language. Through language people are persuaded, their minds are changed, they are shaped, their assumptions and values are challenged and power is exercised. This process is generally two-way. Each participant has some influence over the other.

In the analysis of the therapeutic session conducted by Dr Rogers the text was subjected to four readings. In order to show that the therapist and the client are entering the process with their own assumptions, values and prejudices the narrative of each was presented separately. This demonstrated the differences between the two stories on a number of themes, including the way that power was used. The third analysis unpacked the discursive strategies used within the relationship by the therapist and client respectively. Here, it is possible to see the dynamic of the relationship change and the way in which both therapist and client attempt to control the process through the use of language. The final reading presents an alternative understanding of the way in which power operated within this text. It suggests that there is a sub-text within the session which enables the client to avoid accepting his position of powerlessness engendered by

the constraints of the therapeutic discourse.

In this way the analysis seeks to show that the session takes place within a tightly constrained arena where language is used to mediate action and to re-formulate the client problem in line with the therapeutic model, where the client learns to express himself in therapeutic discourse in order to be heard and the therapist constructs an arena which allows him to achieve the goals dictated by his approach. Thus therapy, as with other social relationships, involves a power dynamic which is relational and often collusive. Both therapist and client attempt to control the therapeutic agenda and manage the relationship through the employment of specific strategies. The analysis shows how the choice of strategy differs between therapist and client and also the way in which each uses their preferred strategies and the effect that they have. To understand therapy we need to understand this dynamic.

For practising therapists this research may provide an alternative lens through which to view the therapeutic encounter. Once power is accepted as part of a therapeutic relationship then it provides another means by which to understand the client and their interaction with the therapist. If power is no longer conceptualised as negative and an element to be denied in therapy then we can start to learn something about how we all use power and the impact that it has on our lives and sense of well-being.

2.0 Review of the Literature

2.1 Introduction

The literature reviewed in preparation for this study spanned a number of disciplines including philosophy, linguistics, psychology, psychotherapy and sociology. The aim of the review is to present a background of theoretical stances and philosophical views relating to the topic of power which will illuminate the understanding of how power works within a psychotherapeutic relationship. The material has been organised into four sections. The first provides an overview of literature relating to power in therapy ending with a critique of the humanistic approach of Rogers (1951). The second section focuses on the role of power within relationships, particularly therapeutic relationships, and the third section looks at the literature on discourse and power, with particular emphasis on post-structuralist theory. The concluding section offers a synthesis of the issues raised in the literature which generated the aims of the current study.

2.2 Power and Psychotherapy

In discussing the notion of power the first difficulty is settling on an agreed definition. However, the range of available definitions raises some interesting questions in itself. Many of these list different types of power without actually defining the essence of power (French and Raven, 1960¹). A common distinction between types of power is that between power that is legitimate based on authority to which people consent, and that which is illegitimate or coercive and to which people do not consent (Weber 1922; Szasz, 1999). Although the nature of power is elusive in the writings of Foucault he uses the word ‘pouvoir’ (authority) rather than ‘puissance’ (force) when referring to power suggesting that he is talking about authoritative power. Dreyfus & Rabinow (1982) see Foucault's post- '69 work as focusing on the action of power in modern

¹French and Raven (1960) quote five types of power – reward, coercive, legitimate, expert and referent.

society. However critics have noted that the concept of power is both vague and ubiquitous at the same time resembling, 'some Eastern metaphysical force that ensnares us all' (Lentricchia, 1982, quoted in Megill, 1985, p.240.). Foucault evades the issue of agency by using terms that fail to identify who wields power or how they do it. Megill (1985) suggests that to understand Foucault's notion of power in his later work we have to look again at Nietzsche's concept of the 'will to power' implying that power is creative. In 'Madness and Civilisation' (1967)², Foucault presented a negative conception of power, as a force which excludes and represses but in the 1970s work he asserts that power is positive and productive, 'Power produces, it produces reality; it produces domains of objects and rituals of truth' (Megill, 1985: 241 quoting from Discipline and Punish, 1977:196). In asserting that power is a creative force Foucault rejects the 'Apollonian' formalism of his earlier work and embraces the 'Dionysian' spirit of hubris, to use Nietzsche's paradigm of the 'Apollonian/Dionysian' contrast from Greek mythology, distancing himself from structuralism. His commitment to the productivity of power represents a move away from his earlier studies of structure in 'Birth of the Clinic' and 'Madness and Civilisation' toward a study of the use of power and language with the aim of presenting a critique of the implicit systems which determine behaviour. The value of Foucault's writings on power lies in the notion of power as a force in relationship . It is not possessed but practised, not an attribute but an exercise (Kendall & Wickham, 1999).

Freud's notion of covert and overt power within the doctor-patient relationship makes us aware of the passive and manipulative way in which power can be exercised by patients, in this case, and also the inter-subjective nature of power in the sense of the balance of power within the relationship (Freud, 1905). The covert exercise of power is

² First published in America in 1965 and in England, 1967 was a shortened version of Foucault's original 1961 publication entitled *Folie et deraison: Histoire de la folie a l'age classique*

developed in Lukes' (1974)³ typology where power is seen to rest with those who manage the agenda and manipulate the wishes of others. The power of the advertising industry attests to the truth of that view.

2.2.1 Institutional power

Authoritative power often derives from a social or professional role or status. So, people such as judges, police officers, teachers, managers, doctors and psychotherapists have authority by virtue of their position. Authoritative power also resides in social systems such as education, religion and medicine. Throughout history and across culture those purporting to heal have held positions of authority within societies whether this healing was of a moral and religious nature such as priests and faith healers or of a medical nature such as doctors, psychiatrists and psychotherapists. In Western culture the increasing importance of medicine as a cultural institution has bestowed on medical practitioners a position of power. They are seen as experts in the field of medical knowledge and patients, not generally possessing this knowledge, are relatively powerless. These social systems often have a complex hierarchy of authority which is implicit but determines behaviour and expectations within that system. Foucault (1967) refers to these as social discourses and sees them as creating conditions of possibility for statements which make some things sayable and prohibit others. In other words a medical discourse which relates to illness and treatment and alleviation of pain through the application of medical knowledge creates a view of reality whereby certain statements are sayable, such as 'I have picked up a virus', but others such as 'I have been cursed' unacceptable.

Challenges to the power of the medical model appeared in sociological writings of the 1970s, which have become known collectively as the 'medicalisation critique'. Ivan Illich (1975), one of the most vociferous advocates of this critique based his stance on the

³ Lukes' also had a third dimension of power – those who were successful in making decisions.

argument that scientific medicine undermined lay people's capacity for autonomy. Studies of doctor-patient interviews supported the claim that doctors were exerting power over patients and implied that they were agents of social control, 'The medical encounter is an arena where the dominant ideologies of a society are reinforced and where individuals' acquiescence is sought.' (Waitzkin 1984:339). This view was echoed in the anti-psychiatry movement (Becker, 1964; Goffman, 1961; Laing, 1967; Laing and Esterson, 1964; Scheff, 1966; Szasz 1961) of the 1960s which based its critique on the, 'hegemony of medical model psychiatry, its spurious sources of authority, mystification of human problems and the more oppressive practices of the mental health system' (Barney 1994: 19).

Foucault's 'Madness & Civilisation' published in England in 1967 was seen as part of the anti-psychiatry movement of the time. The book was about how the concept of madness emerged against a background of specific power relationships, particularly those of separation and how the concept of madness transformed the institution of separation by introducing custodians like psychiatrists. However both the medicalisation critique and the anti-psychiatry movement appear to have had little impact on the dominance of the medical model in our culture. Lupton, (1997), following Foucault, offers an explanation in the form of a critique of the medicalisation critique pointing out that the medical profession, in addition to receiving power by virtue of their privileged position in society, is also given power through the complicity of their patients, 'Rather than being a struggle for power between the dominant party (doctors) and the less powerful party (patients) there is a collusion between the two to reproduce medical dominance.' (Lupton, 1997:98).

In other words the dynamic of power within relationship is a much more subtle process than the use of violence or coercion. It is a form of persuasion, through the use of rhetoric, that certain ways of behaving and thinking and feeling are more appropriate

and healthy than others,

‘Power is not a possession of particular social groups, but is relational, a strategy that is invested in and transmitted through all social groups. This more complex view of power goes some way to recognising the collusive nature of power relations in relation to medicine’ (Lupton, 1997: 99).

This, indeed, may be a possible explanation for the continuing dominance of the medical model, but it is also an interesting thesis to apply to the relationship between client and therapist within psychiatry and psychotherapy where talking and rhetoric are the tools of the trade. For healing to be successful one must have faith in the healer and in trusting someone to make us well we invest them with power.

The critique of psychotherapy initially followed the anti-psychiatry approach (Szasz, 1961; Laing, 1967; Goffman, 1961; Breggin, 1993) by presenting psychotherapy as fundamentally abusive, sexually, psychologically, emotionally, financially and sometimes physically (Masson, 1988; Howard, 1996). Spinelli, (1994) argues that although the abuse or misuse of power in psychotherapy has been a concern over the recent years little has been said about the way that the inherent values, assumptions and attitudes of therapeutic theories have made the abuse of power more likely. However, much has been written in the last decade from a sociological and critical psychology perspective on the way in which psychotherapy has become a dominant force in western society, (Rose, 1985, 1989; Parker, 1996, 1997, 1998; Gergen, 1991, 1994; Smail, 1996; Pilgrim, 1997).

The core of this analysis has been the focus of western culture on the individual and the desire for self-knowledge which has elevated psychologists and psychotherapists to the role of experts and therefore into privileged positions of power. Barney argues that power is now wielded in a much more subtle way than that used by the psychiatrists of the 1950s. He sees psychology as the new socialising force in our society. Through

personalising and de-politicising distress and promoting the ideology of individualism psychology is guilty of perpetuating the myth of individual freedom and responsibility, 'Individualism, reflected by psychology and reinforced by it, promotes the glorification of the self, 'self-actualisation', and faith in the capacity of the individual to transcend society' (Barney, 1994: 25).

The implication seems to be that we are no longer a social society, developing a sense of self from our position within a social and religious context, but rather, are disconnected, separate individuals striving to reach an individual potential, independent of those around us. As psychology is defined as the scientific study of the individual, the psychologist becomes the expert in matters of understanding the self.

The transformation of the self, in social constructionist terms, has involved mainly a move toward a more autonomous self. There appear to be two main consequences of this. The first is that the self becomes powerful and liberated with infinite potential, changing from '...a relatively docile, passive recipient to self-controlled, radical and enterprising' (Nettleton, 1997), providing an image which resonates better with the prevailing ideology of the 1980s and 1990s and offers everyone the potential to be what they want to be. Rose explains the power of psychotherapy thus: 'It promises to make it possible for us all to make a project of our biography, create a style for our lives, shape our everyday existence in terms of an ethic of autonomy' (Rose 1990:254).

The second is that within this autonomy is contained the responsibility of self-policing (Foucault, 1977). Overt social control is no longer needed as internalised social responsibility takes over. Parker argues that notions of selfhood are constructed in western culture and that ideas about psychological health are located in networks of power. The 'psi-complex' is '...an intricate network of theories and practices ...which govern how far we may make and remake mind and behaviour and the ways in which emotional deviance may be comprehended and cured'(Parker 1997:3).

This complex provides us with a vocabulary to discuss the inner world in a similar way to the jargon of psychopathology, which under-pinned the medical model. The notion of freedom to explore the inner worlds of the psyche is illusory, the normalising function of therapeutic discourse is now very carefully hidden within the ideology and language of humanism. By suggesting that therapy is client centred the power, in theory, but also the responsibility is placed firmly with the client, ‘...psychotherapy can easily become, and indeed frequently does become, a kind of disguised moral campaign which places colossal and entirely unreasonable demands on the individual’ (Smail, 1996:44). The ‘conditions of possibility’ (Foucault, 1977) are determined and the trend toward self-surveillance continues, creating a much more effective means of social control than any overt system of disciplinary power.

2.2.2 The person-centred approach

‘Carl Rogers, like so many within counselling wrote extensively on the power of love and nothing on the love of power. A failure to confront the reality of power leads to naiveté, just as a denial of the existence of love is a recipe for cynicism’ (Howard 1996:70.)

The stress that Rogers placed on the unreserved, unconditional respect for the individual reflected the pioneer culture of the USA at the time. He was greatly influenced by American pragmatism of John Dewey and particularly the interactive relationship between the individual and society. The democratic spirit of the time placed emphasis on the individual to choose freely in terms of politics and religion. These influences led to an approach characterised by:

- sensitivity to the views and feelings of others
- an aversion to authoritarianism and an affirmation of permissiveness
- an equality of opportunity for self-development (Cushman, 1992).

For Rogers the individual should come first; should have primacy over society, 'For society to control and direct personal growth is to reverse the direction of the actualisation process that man is' (Van Belle 1980: 98).

Theoretically the approach balanced a phenomenological philosophy with a scientific modernist paradigm. With its origins in humanistic psychology the person-centred model is characterised by four themes common to all humanistic models:

- Commitment to a phenomenological approach
- Belief in the actualising tendency involving growth, self-determination and choice
- Fostering the construction of new meanings
- The principle of person-centredness evidenced in relationship.

Rogers postulates the self-actualising tendency as the main motivator of the individual.

This is conceptualised as a process not an entity. Such a model places enormous store in the fundamental 'goodness' of basic instincts. In other words once all the 'baggage' accumulated during life experiences is stripped away what is left is a core self that is genuine and good and can be trusted to lead the individual toward psychological health.

A more developmental view would argue that the self is formed through life experiences. The social constructionist model goes further by arguing that there is no independent self but rather a construction based on social, cultural and political discourses. For Rogers behaviour is about satisfaction of needs: it is a reaction to the perception of reality. The real world is only important as a background for the actualising process of the organism. This actualisation process is inherent – the organism shapes itself which leads to differentiation and assimilation and growth.

Experience for Rogers is within the organism, not through interaction with the outside world, and reality and truth are to be found within the individual.

The therapeutic process is de-mystified by being self-aware and open about the process and relationship within the session. Self awareness, reflexivity and self-monitoring

are key themes in person-centred therapy and the assumption is implicit that these techniques will bring the client and therapist in to a more authentic relationship where the conditions will be right for the client's growth toward autonomy.

Rennie, (1998) points out that although the approach emphasises the importance of empathy between client and therapist it does not deal honestly with the relationship itself. There are inherent issues of power within the therapeutic relationship which are not considered within Rogers' model. For example, it is possible that the client's growth toward self-actualisation is a property of the therapeutic relationship rather than a change in the client's personality. The role of the therapist as facilitative rather than interpretative may be naïve. Van Belle, (1980) argues that insight is not possible without interpretation from the therapist, '...insight does not occur spontaneously in client-centred therapy but rather it results from the interpretation of reality which the therapist intends' (p.148).

There may be a misreading of the client's development within the therapeutic process in Rogerian theory. The warmth of the therapeutic relationship may lead to greater dependency on the therapist rather than a move toward self-actualisation. Rogers' views on dependency/independency are not clearly expressed. The therapist's focus on emotion further encourages the client to doubt their cognitive ability; the client is dependent on the selective attention of the therapist.

Erwin (1997) argues that there is a paradox of determinism and freedom existing alongside each other in Rogers' theory. If there is no free choice there can be no autonomy and if the pre-determined goal of therapy is to promote autonomy then freedom is denied.

The individualising of the client's problem within the person-centred approach echoes the medical model by situating the problem within the client rather than the environment. Self-actualisation is defined as respect for the uniqueness of the

individual, the belief that individuals are able to change given the right conditions and the belief that this growth process is inherently toward the good. There exists here an assumption about agency; that individuals are free agents, able to make choices which move them toward self-actualisation and also that they are aware of what is good for them. Knowing what is right is linked with the idea of getting in touch with the true self, or in Gendlin's terms the 'felt sense' the leading edge of experience (Gendlin, 1970). This discovery of the 'real self' is critical in Rogers' work. He is committed to an essentialist self. Although he credits the term 'self' to Kurt Goldstein (1939) who uses the term to mean an awareness or perception of the self, Rogers talks of self as though it were an inner agent. Rogers appears to get into a circular argument when he argues that the self-concept is determined by perception and the self concept determines the nature of perception. Rogers' self is 'ego-less' which leads to phenomenological solipsism.

The person-centred therapist is not trained in technique, as such, but in 'ways of being' and authenticity. The therapist is not the expert and the client takes responsibility for themselves. However, the assumption within person-centred therapy that self-awareness is gained through the experiencing of emotion relegates other equally important aspects of human functioning such as cognitive capacity and learned behaviour to an inferior position.

Freidman (1992) identifies the touchstones of Rogerian therapy as self-actualisation and the I-Thou relationship but sees these as fundamentally incompatible,

'Either the I-Thou relationship is seen as a function of self-actualisation, and the real otherness of the Thou is lost sight of in the emphasis on the development of the organism, or the I-Thou relationship is seen as a reality and value in itself, in which case self-realisation becomes a by-product and not a goal and, what is more, a by-product that is produced not through a pseudo-biological development, but rather through the meeting with what is really other than self' (Freidman 1992: 40).

The goal of promoting the client's autonomy is one which is widely accepted in psychotherapy (Erwin, 1997). Erwin describes inner autonomy as enhancing the capacity to reflect on one's preferences, wishes and values and to change them when it is considered rational to do so; to eliminate one's defective desires, wishes and capacities; and to increase the capacity for self control. The relationship between autonomy and self-control is interesting as self-control is generally construed as behaving in a socially acceptable manner. Therefore, autonomy and self control are incompatible.

Holmes and Lindley (1989) also argue for the prioritisation of autonomy. It is seen as something intrinsically good. But what is conceived as 'good' is value-led and culture specific. It is immersed in the ethos of the individualism of western culture. Person-centred therapy makes many assumptions regarding the relationship between autonomy and mental health and fails to address many pertinent issues relating to the concept of autonomy. The over-emphasis on the importance of personalisation and growth may be at the expense of other aspects of human functioning. Clients seeking therapy may prioritise other things like symptom relief or search for meaningful relationships or may be motivated to change specific behaviours rather than whole personalities. They may not want to be autonomous but may wish for direction and dependency within a relationship. The privileging of autonomy and independence in person-centred therapy denies the possibility of other client goals such as relational dependency and interpersonal co-operation.

2.3 Power and Relationship

'Any act of involvement or relationship, excludes neutrality; relationship is power in flux.' (Spinelli 1994: 121).

The rise of the therapeutic relationship has been a cornerstone of what Parker terms the

therapy industry and its influence, it has been argued, may be due to the way in which it fills the niche left in our industrial, post-modern society by the decline of religion, family and community (Parker,1997). Ordinary human relationships are considered to provide support and care which may in the past have been sufficient to meet our emotional needs and it is claimed that psychotherapy has developed partly as a response to the decline of these forms of traditional helping in our society, (Clarkson, 1995). However the lack of alternative, more traditional forms of support, means that the power of psychotherapy as an institution is further enhanced. In Foucauldian terms the privileged discourse has moved away from family and religion towards the individualism of psychotherapy.

Within psychotherapy research over the last twenty years there has been increasing evidence of the importance of the therapeutic relationship as a critical factor in the effectiveness of psychotherapy itself, (Bergin & Lambert, 1978; Hill, 1989; Luborsky et. al. 1983; Norcross & Goldfried, 1992.) In addition to exploring the influence of specific factors such the match between client and therapist characteristics, (Garfield, 1980), there is evidence that the relationship between the therapist and client is one of the most influential factors in therapeutic effectiveness, (Frank, 1979). The nature of this relationship differs across theoretical models of therapy. For instance, a therapist working in a cognitive-behavioural model will expect to develop a directive, educational type of relationship with the client, whereas a psycho-dynamically oriented therapist would strive to form a relationship conducive to nurturing a transference reaction in the client. But, it is within the humanistic tradition that the therapeutic relationship is elevated to its most prominent position. In fact it could be said that, for Rogers the relationship is the therapy, it provides the conditions within which the client can move toward her goal of self-actualisation. (Rogers, 1961; Van Belle, 1980). Rogers believed the therapeutic relationship to be an example of relationships in

general, 'There seems to be every reason to suppose that the therapeutic relationship is only one instance of interpersonal relationships and that the same lawfulness governs all such relationships' (Rogers, 1961). Rogers uses the term 'lawfulness' to imply that a common set of rules or norms are inherent within all relationships and the therapeutic relationship is just one example. However, the rules or norms within other relationships such as parent-child or teacher-pupil are usually based on adherence to social norms relating to roles and are generally a response to managing difference in status and power between the participants. Therefore, according to Rogers' proposition the same should apply to the therapeutic relationship but the topic of status and power in therapeutic relationships rarely forms the basis of discussion in Rogers' work.

Person-centred therapists claim that techniques are secondary to attitudes and the aim of therapy is to understand empathically the inner world of the client. The therapist is not a healer but a facilitator of healing in Rogers' view. For Rogers the role of the therapist is to get within the client's internal frame of reference, to experience the client's world as though the therapist were the client but without the emotional involvement. So, the emotions remain those of the client not the therapist and this detachment allows the therapist to facilitate the client's journey by keeping one foot in their own world. This entry into the world of the client is accomplished through the processes of acceptance, empathy and congruence. The therapist exercises respect and trust for the human being that is the client and the world that is experienced by the client. Through the development of a trusting relationship which respects the separateness of the client the growth towards self-actualisation can begin. Change comes through relationship.

The fact that tensions do exist around compliance in person-centred therapy sessions suggests that the relationship may not be as equal as Rogers intended. There is a distinction between the desires and the needs of the client. The theoretical discourse within many models of therapy is 'no gain without pain' and the therapist may

encourage clients to face painful situations in the belief that the working through will lead to personal growth and development. However, clients, understandably, may be more concerned to find less painful ways of resolving their problems. If the therapist follows the client's lead then painful working through of problems may be avoided totally. As this is rarely the case it seems likely that the therapist exerts some influence on the client to guide them through the therapeutic process as constructed within the relevant therapeutic model. Rennie quotes the following example from a transcript – the client is speaking about the two-chair work in Gestalt therapy, 'I can't stand it. But I normally don't resist. A couple of times I will say, and will stop it. But normally I hate it and he knows I hate it but I do it anyway' (Rennie, 1998:117).

Rogers began by focusing on the intra-personal processes of the individual which resulted in an asymmetrical relationship – the emphasis on the client and not the therapist - but later he defined any inter-personal relationship as therapeutic and both parties were considered to change as a result – the relationship becomes symmetrical. The process is one of growth for both client and therapist, '...if I am to facilitate the personal growth of others in relation to me, then I must grow, and while this is often painful it is also enriching' (Rogers, 1961:51).

Rennie, (1998) challenges Rogers claim of symmetry in relationship by arguing that the dynamic tended to be one-way. The therapist tends to check on the client's impact on him rather than his impact on the client, and to learn more about the client's motivations than to reveal his to the client. The therapist is present as an active listener but not as a personality. Therapists here are operating within a traditional dualism where clients are objects (patients) and therapists are subjects (agents) and there are different rules for each. In the role of expert, therapists assume they have greater cognitive privilege than clients. Rennie draws parallels between the therapist's role in person-centred therapy and in psychoanalysis. In both, he suggests, the therapist is only important in a

technical sense. There is a similarity between the person-centred therapist's listening attitude and the blank screen of the psychoanalyst.

The issue of mutuality is debated in a dialogue between Martin Buber and Carl Rogers in 1957 moderated by Maurice Freidman where Freidman argues that Rogers did not claim the relationship was mutual, 'At first glance it appears as if Rogers is talking about total mutuality . He never is. He never suggested that the client is concerned with Carl Rogers' problem, however much the client may help Rogers' (Freidman,1992:41). Buber was happy to suggest that there are 'normative limitations to mutuality' (Freidman, 1992:42) and the I-Thou relationship can still exist within these limitations. However Rogers was loathe to relinquish his emphasis on equality and he described the client's 'way of looking at his experience, distorted though it might be, is something I can look upon as having equal authority, equal validity with the way I feel life and experience it' (Freidman, 1992:43). The phrase, 'distorted though it may be' clearly demonstrates that Rogers is beginning from a position of power in that he feels able to make this judgement.

For Rogers the nature of the therapeutic relationship is one of acceptance and caring and the aim is to empathically understand the client's world, while laying aside one's own values and beliefs. In the rhetoric of humanism the client is empowered in her journey towards self-actualisation, autonomy and fulfilment by a non-judgmental and caring therapist meeting her on equal terms. Common-sense notions of equality involve an element of reciprocity - of give and take which seems to be absent from the person-centred therapeutic relationship. While the therapist listens to the clients self disclosure she does not reciprocate with her own. As Pilgrim states, 'Clearly the relationship between therapist and client is initially neither reciprocal nor equal' (Pilgrim, 1983: 139), and in Howard's words,

‘ Such an uneven sharing of confidences makes for an unhealthy, unequal relationship, leaving us (the client) exposed and vulnerable. Knowledge is power. If I (the client) become transparent while you (the therapist) remain opaque, the empowerment will probably be yours more than mine.’ (Howard, 1996:69).

Rogers advises that the therapist must aim for transparency in order to combat the role of expert and nominated ‘genuineness’ as the most important of the core conditions. But the transparency required of the therapist and that of the client are of different types and serve different purposes. It is interesting to note that the notion of responsibility, usually associated with the concept of power in everyday life, is rarely discussed in debates around power in the therapeutic relationship. If the client is less powerful than the therapist then it may follow that she also holds less responsibility. An increase in responsibility is generally accepted as a therapeutic goal. In order to take responsibility the client must be empowered but if power is inversely related to transparency, as Howard suggests, then as the client becomes increasingly transparent she will become increasingly less responsible.

Rogers used Buber’s term ‘I-Thou’ relationship to describe his understanding of the therapeutic relationship, ‘...a timeless living in the experience which is between the client and me’ (Rogers, 1961: 202). This is an existential meeting where the therapist is not an expert, is not using theory and the healing power resides in the relationship itself. Person-centred therapists rarely speak of power; instead they use a rhetoric of love, acceptance and respect. The relationship is akin to friendship only better. ‘...the most potent aspect of psychotherapy is the solidarity afforded patients through their relationship with someone taking an intense, on-going interest in their welfare’ (Smail, 1977:169). Rogers’ belief that the role of the therapist is to facilitate the client’s journey toward self-actualisation through merely providing the necessary supportive conditions for growth provides us with a view of therapy where the client is in control and the

therapist follows, 'If I can provide a certain type of relationship, the other person will discover within himself the capacity to use that relationship for growth, and change and personal development will occur' (Rogers, 1961:33). Pilgrim forcefully suggests that the seductive nature of the rhetoric of humanistic approaches enables the issue of power to be overlooked but in actual fact it is in this type of relationship that power can operate most effectively,

'Given the humanistic mandate associated with psychotherapy and a genuine, central concern of its practitioners to pay heed to the experience of clients, it is easy to forget the question of power. Intimacy and empathy can be preconditions of oppression and abuse as well as of helpful interventions (Pilgrim, 1997:4).

The humanistic focus on the phenomenological is challenged by the social constructionist approach.

'Foucault, perhaps more than any contemporary theorist, has sensitised us to how readily structures of power utilise 'therapeutic' and 'liberating' speech as a ruse to control the subject through the subject's own voice. Power operates by convincing us of the selves we want and need to become, in order to be 'true' to ourselves' (Frank, 1998).

Studies have shown the subtle way in which therapeutic discourse evolves throughout the therapy session as the therapist takes the client's initial presenting problem and '(re)-formulates' it into a more 'appropriate' therapeutic problem, (Davies, 1986; Eaton, in press). Clients rarely protest (or perhaps notice?) that their problem has been re-invented.

Power and influence are at their most potent within the framework of a caring, non-judgemental and altruistic relationship. The power of love will always be stronger than the power of hate and a therapeutic relationship founded on the characteristics of love commands an extremely powerful position as a healing force. Take this relationship and place it within a social context where the ethos of individualism and self-awareness

have become paramount, where the expectation of happiness and fulfilment are inherent and the political has become the personal and the therapist occupies a position of unparalleled power. This is not to say that the therapeutic element in therapy resides in the power and responsibility of the therapist – in fact this may well be the case – but to fail to address the way in which power operates in therapeutic relationships or to deny its presence or even to advocate for its elimination prevents an exploration of therapeutic process which may be illuminating .

2.4 Power and Discourse

‘In all conversations there is a hidden patterning of power’ (Miller Mair, 1989:40).

The study of language in the modernist era was based on the belief that language was representational. It constituted a set of signs which represented thoughts and inner experiences. This process was independent of the environmental context and the inherent assumption was that language was universal and in some way reflected ‘reality’ and ‘truth’.

Ferdinand de Saussure (1857-1913) is generally credited as the founder of both modern linguistics and structuralism. The simplistic notion that language is a system of signs which refer to real objects was criticised at the turn of the twentieth century by Saussure who argued that what is important in language is the relationships between words and in particular the differences between them. The distinctions between words are critical in the understanding of the utterance. Language is understood in terms of contrasts between different words and the way that words are positioned within speech. The way in which language is constructed and used varies between cultures. As there is no natural or inevitable bond between words and objects language is essentially an arbitrary system and can never be an innocent reflection of reality. It is dependent on the conceptualisation of reality within the particular culture and works as a self-governing system in the present (Saussure, 1974).

For Saussure, then, the aim of semiology is to elucidate the underlying system of differences that gives sense to any domain of meaning (Potter, 1996). Saussure argued that verbal and written language offered the best model of how signs made meaning through a system of arbitrary social conventions. This led to the development of semiology or the 'science of signs' which could be seen as a branch of structuralism as it is inferred that language is structured and rule-based. Although the relationship between the signifier (e.g. the word) and the signified (the concept to which the signifier gives rise to) is arbitrary, understanding is always in some sense constrained by rules and conventions. In this way communication is possible if people share conventional meanings. These meanings are produced by the internal relationships between the parts rather than through reference to the author or the natural world. Personal intentions or individual experience do not affect the creation of meaning. The means of representation both exceed and precede decisions made by individuals.

The notion of shared understanding within language as a result of an underlying structure can no longer be taken for granted. Shotter, (1993), paraphrasing Garfinkel, claims it is the exception rather than the norm that we immediately and accurately grasp another person's meaning from the words they speak. Rather, speech is understood through a process of checking, challenging, reformulating and elaborating until some level of understanding is reached. Talk is not about an accurate exchange of information. It is a social activity involving the construction of a social relationship from within which the meaning of the words is understood, negotiated and agreed.

Post-structuralists challenge any framework that posits some kind of internal structure and have criticised structuralism for obscuring the practical nature of language, that is the way that language is actually used, in their preference for identifying an underlying theoretical structure. This structure itself is ambiguous as it is not clear whether it exists in the language itself or is a metaphor or a cognitive concept.

Barthes, (1983) a literary critic, straddled the divide between structuralism and post-structuralism. One of his contributions to semiology was the notion of second order signifiers. He proposed that any signifier could, through association, act as a signifier for new signs. This was a theory that explained the way that language evolves through common usage.

French litero-philosophy in the 1960s had to find a new direction after the exhaustion of existentialism and had to move away from the German philosophy of Husserl and Heidegger. This way was led by Derrida and Foucault. From the outset Foucault sought to free epistemology from Descartes by rejecting the idea of immutable scientific truths. He followed Nietzsche in the assertion of the fluidity of social meanings. Things do not have meaning in themselves but only in so far as they have meaning imposed through interpretation. He sought to distance himself from structuralism as early as 1967, 'I differ from those who are called structuralist in that I am not greatly interested in the formal possibilities presented by a system such as language' (Foucault, 1967: 26).

Beginning in the 1960s Jacques Derrida published a long series of books concerning his own post-structuralist blend of literary analysis, philosophy and linguistics known as deconstructionism. His aim, in common with the structuralists, is to understand meaning but rather than searching for underlying structure he is more interested in the plurality and instability of meanings. However, he takes from Saussure the idea that language is a self-referring, self-regulating system but claims that the structuralists still hold onto a depth model of meaning which he rejects. The structuralist model, he claims, still gives meaning a source, ideas are used to cut through a text to reveal its true linguistic machinery; meaning exists within the rigorous structure of language itself. For Derrida, meaning is determined by the limitations of the social and historical conditions that frame that particular knowledge. For example a conversation with a GP will be framed within a medical discourse not a philosophical or magical discourse although these

alternatives are within the bounds of possibility. In other words there are certain assumptions built into activities which limit the number of possible meanings of that activity. The aim of deconstruction is to uncover these hidden assumptions and expose the suppressions and exclusions upon which texts are constructed and to demonstrate how all knowledge is a product of a particular context. Deconstruction seeks to expose how the language used in particular fields both creates the essential presence through which knowledge can claim to be true and conceal the means by which it creates this presence. There is an illusion of coherence. For post-structuralists there are no facts only interpretations.

The value of Derrida's work for post-modernists lies in his undermining of the notion of meaning which consequently subverts the reading of all texts. Truth is a production of discourses. Text, whether written or spoken, is iterative, it is transformed constantly and meaning is constructed. It is not the product of the original author and interpretation itself is problematic. Text does not contain the simple intentional authority of the original author. Language is relational not representational and therefore the reader of the text creates meaning which may or may not coincide with that of the original author. Foucault is not concerned with the notion of truth, rather, his aims are to understand the links between power, ideology and forms of subjectivity. His focus is on the way that knowledge is produced. In this context truth relates to the institutions and social organisations themselves. For example, a specific therapeutic model provides a particular version of the truth. As new institutions like psychotherapy come into being they create new discourses that in turn create new objects and also new subjects. For example, the concept of alienation of the self is only meaningful within a discourse that has a notion of the self and a social world that this self may become alienated from and a notion of alienation as undesirable. By creating a discourse of emotional distress which is seen as undesirable the roles of client and therapist are also created. These

roles are new, they did not previously exist and are not linked to an objective truth and do not represent an objective reality. As new discourses are produced so are new positions from which to speak and new ways of speaking and new relationships.

Social constructionism is situated within the post-modern tradition owing much to the deconstructionist views of literary critics such as Derrida and philosophers such as Foucault. Social constructionism takes issue with the modernist view of an objective world that exists outside of our experience of it. Whereas constructivists believe that we construct notions about this world in the form of percepts and constructs developed through our interaction with it, constructionists believe that meaning evolves in the space between people and is mediated through language (Anderson & Goolishian, 1988; White & Epston, 1990; Kogan & Gale, 1997, McNamee & Gergen, 1992; Shotter & Gergen, 1989). Speech and communication are creative and formative processes.

Narrative therapy is an example of a post-modern approach increasingly adopted by family therapists where clients are encouraged to tell a coherent and consistent story about themselves, a narrative. This coherence, it is argued in social constructionism does not come from a common cognitive construction but is historically and politically constituted. Language is not just about communicating information it is about, 'legitimising, challenging, supporting or ironising, endorsing or subverting what it describes' (Parker, 1997: 290). Discourses are seen in the context of wider systems of power. The way that we make sense of things is limited by these wider systems - they limit our understanding of ourselves and our world and they determine the subject positions that are open to us. Lakoff, (1982) in his paper on persuasive discourse and ordinary conversation attempts to look beyond the surface comparisons of the characteristics, similarities and differences between these two types of discourse. He is interested in the way that the two forms of discourse serve a different purpose and how this then drives the differences in structure and performance. Persuasive discourse is

defined as, ‘ the attempt or intention of one participant to change the behaviour, feelings, intentions or viewpoint of another by communicative means’ (p. 28). In this culture persuasive communication tends to have negative connotations. We associate it with brain-washing, an infringement of personal freedom of choice a threat to that paramount virtue of reciprocity. Reciprocal talk is somehow ‘good’ and one-way talk is somehow ‘bad’. However Lakoff argues that if talk is blatantly one way and non-reciprocal it cannot be seen to be dangerous and types of discourse should not incur value judgements What may however be more of a threat is talk which is overtly egalitarian and reciprocal but at a deeper level is actually power wielding and persuasive. In ordinary conversation there is always a reciprocal element. One speaker does not deliver a lecture to the other who plays the role of a silent audience. Instead, each takes a role in a conversation that is governed by rules related to reciprocity. Each participant has the same options and privileges. In contrast, a persuasive discourse is non-reciprocal. Here, the speaker holds the floor, makes the decisions about the direction of the discourse, determines beginnings and endings of utterances and so on. The audience in this case does not have to contribute much at all other than to listen and, if the speaker has been successful, to indicate that he/she has been persuaded. Therapeutic discourse, Lakoff suggests, lies between the two and inhabits an intermediary state. It contains characteristics of both ordinary conversation and also of persuasive discourse,

‘ there is the appearance of an egalitarian, reciprocal conversation, but in terms of deeper intention, the reciprocity turns out to be only superficial. The therapist can ask questions which the client soon learns not to ask; and if the latter should attempt to ask such a question, the therapist, rather than give an answer, will usually treat the question as a tacit invitation to ask another question, or make an interpretation’ (Lakoff 1982: 27, 28).

The anomaly in therapeutic discourse is that although the client typically holds the floor

for the majority of the time, which is usually a sign of power in conversation, the therapist maintains power through other means. For instance, it is the therapist who determines beginnings and endings and decides on the meaning of the contributions made by the client. Therapeutic discourse is a complex example because it is both non-reciprocal and bilateral. Both participants make true contributions to the conversation and in fact take turns (usually an indication of reciprocity) but the contributions vary in their surface forms and are open to different interpretations. Ordinary conversation is expected to be spontaneous and include hesitations and gaps rather than be smooth flowing as is often the case with persuasive discourse. Therapeutic discourse on the surface takes the form of ordinary conversation and does include a spontaneous element, certainly within the clients' narrative, but when unpacking the therapist discourse there is often evidence of a more prepared script. However it is a script that must be flexible and responsive to the client utterances and therefore is not equivalent to persuasive discourse in the form of a lecture for instance. Ordinary conversation is full of rituals and well-worn phrases. It has surprisingly little novelty. Persuasive discourse however, always strives for novelty. It is the novel element that makes it persuasive. This may be apparent at the level of content or in the structural format through use of words and phrases that are unfamiliar to the listener. In therapeutic talk the client is often exposed to a vocabulary and style of social intercourse which is unfamiliar. This puts the client at a disadvantage, it could be argued, but also contains that element of novelty that makes the discourse persuasive.

Rhetoric was defined by Plato as, 'the art of influencing the soul through words' and for critics of psychotherapy it is in this art that therapists excel. Rogerian rhetoric has been used as a method of persuasion to be used in debate and argument. (Brent, 1996) The goal is to identify grounds of shared understanding as a precursor to a means of effective interaction. The technique of reflecting back is a form of anti-argument in

that when one repeats back the argument of the protagonist before moving on to make one's own point it enhances the argument and dilutes the emotional content. It also works through manipulating the opponent to believe that you are on their side. Studies of women in conversation suggest that they tend to engage in more transactional and co-operative behaviour than men. Some feminists suggest Rogerian technique is a feminine style of interaction, promoting self-effacement and giving in to others (Lamb 1991).

Shotter, (1993) is interested in how talk is used to construct social relationships. He is concerned with a conversational version of social constructionism wherein language is used rhetorically to respond to those around us and to make connections between speakers and audiences which may lead to changes in sensed reality and eventually to action. The emphasis on the social embeddedness of what we believe to be true is reflected in the developments within literary theory, semiotics and rhetoric. The reality of the world and of self, it is claimed, is created through shared conventions of discourse (Mc Namee & Gergen, 1992). Transformations of this reality is a relational matter, it cannot be achieved by a single individual. If our shared discourses make certain things visible to us they must also make other things invisible. It is our background ethos that determines what is both ordinary and extraordinary (Shotter, 1993).

Vgotsky, (1978) conceptualised language as a psychological tool. He believed that words work in a non-cognitive way to shape and form our embodied selves and to make us act and perceive in different ways. The thoughts and ideas of an individual are a type of social relationship – an instructional type. Vgotsky is concerned about the means by which concepts are formed. We use words or signs to direct our own mental processes and to organise our concepts in a socially intelligible way. Language is therefore an instrument which allows us to 'instruct' ourselves in the gathering and organising of perceptual information and also in the ordering of it and the subsequent formulation

of a plan of action. However in converting the sensed thought into the speech act there is always inaccuracy, the transition of thought to word is through meaning and this is constantly evolving through a process of back and forth negotiation, ‘In our speech there is always the hidden thought, the subtext’ (Vgotsky, 1986:251).

Even in our formulation of our private thoughts, Vgotsky argues, we engage in this process of negotiation with ourselves. He calls this inner speech.

Bakhtin, (1981) focused on the utterance as the standard unit of language because he claimed that the utterance was where the linguistic system met the situational context. Utterances were more than just the implementation of the linguistic system, they are extra-linguistic or contextual. The utterance is linked to the notion of ‘voice’. The dialogue is of a rhetorical-responsive form on behalf of the speaker and the listener. The utterance belongs to them both and the important area of study in Bakhtin’s view was the gap between the utterance of the speaker and the reply by the listener. This gap is the boundary between two consciousnesses. Here inhabits the life of the communicative act – ‘the interactive gap’ (Shotter, 1993), where meanings can be transformed and stabilised. Bakhtin distinguishes between authoritative discourse which involves the transmission of information only and internally persuasive discourse which is participative and enables development. In therapy there must be a transition from the former to the latter mode. Therapy is based on traditional views of language involving transmission of facts – the client’s story to the therapist and the therapist’s response from the therapist to the client. The dialogic view would be that the client is actively constructed through the listening process. In order for the client to feel understood there must be a context which exemplifies shared values. The nature of this context is determined by the therapist who provides the receiving context. The type of receptive environment provided determines what is said as well as how it is received,

‘Thus, the utterance does not entirely belong to the speaker, it belongs to at least two people. It also does not belong entirely to the present but also to the future. Like bridges, utterances have to have both ends to exist – they are two-sided acts, the products of reciprocal relationships between speakers and listeners of present and future’ (Riikonen & Smith, 1997: 55).

The contradictions between a transmission model of communication (Wertsch, 1998) and the Bakhtian translinguistic model may be partially resolved by the approach offered by Lotman (1988). This model suggest that texts serve two functions (functional dualism) – to convey meaning and to generate new meaning. When the worlds of the speaker and the listener are very similar then there is a high degree of univocality which allows a relatively simple transfer of information. This model has been most attractive to theorists who have focussed on the transfer of messages in this way sometimes assuming a univocality where none exists. The second function in Lotman’s view is by far the more interesting and relates to Bakhtin’s notion of multivoicedness. For Lotman it is this function that allows for the semiotic study of culture.

Returning, finally to person-centred therapy, there is an understanding that the client controls the therapeutic process and therefore the conversation. Therapists use meta-communication techniques to further empower the client and give them more of a sense of control. However, the meta-communication itself is often providing a framework within which the client can structure and make sense of their situation. It is natural for individuals to respond to cues, no matter how small, in order to monitor their effectiveness or acceptability or general impact on the other. In this way, it could be argued, wider social and political discourses are imposed on the client, ‘Clients often arrive with their own ideas of what is wrong with them and what they need. Of course, they may eventually see things otherwise as a result of their interaction with the counsellor’ (Rennie, 1998:113). Rennie argues that it is in the direction of process

control that the counsellor exerts their power – they are an expert on process.

Techniques such as reflection are a means to communicate empathy and empower the client. However it might be suggested that therapist utterances operate as positive reinforcers and actually shape the client's speech. Reflecting back may be taken as authentication

2.5 Conclusion

The issue of power and therapy is a complex one as can be seen from the review presented above. In psychotherapy power is rarely wielded by a powerful therapist over a submissive client but rather exists and is exercised in much more subtle ways. This is not to say that abusive therapists do not exist and as Masson, (1988) has documented there do appear to be quite a few instances of this phenomenon. However, such behaviour, unfortunately, characterises a wide variety of relationships and is relatively easy to understand even if not condoned. What is more interesting is the exploration of the dynamic of power within more equal relationships. The discussion of person-centred therapy found little examples from Rogers writings on the nature of power in the therapeutic relationship. For Rogers the therapist must strive for equality and mutuality and do all that is possible to avoid the role of the expert or any temptation to take a powerful position over the client. Lupton's (1997) notion of power through complicity is a more sophisticated understanding of the way that power is both relational and collusive. The patient (client) for reasons such as abdication of responsibility for example, may prefer to collude with the notion that the doctor (therapist) is powerful. As with faith healing it may be the belief in the power of the therapist that is the healing factor.

The discussion around the nature of relationship revealed that in person-centred therapy the therapeutic relationship is seen as the core of the therapeutic process. It provides

the medium for growth and change but does so in almost an inert manner. Although Rogers does claim that the therapist should also change as a result of the therapeutic process and thereby infers an almost symbiotic relationship between therapist and client, he does not examine the mechanisms by which the two parties influence each other. Rogers analogy of the plant (client) and soil (relationship) falls down here as the essential characteristics of the fully grown plant are determined by the nature of the soil. In the same way there are characteristics inherent in the role of the therapist and his theoretical orientation which influence the therapeutic process. The therapist brings to the encounter, as does the client, a self⁴ which is made up of gender, age, class, status, education, life experiences, training and so on. The relative power of the therapist over the client is a function of these elements. Rogers may argue that this must all be set aside in order for the therapist to enter the client's world but this alone will not negate the power invested in these roles or the way that the client perceives their importance. For Rogers the goal of person-centred therapy is to facilitate the client towards a state of self-actualisation. Such a notion is value laden and presumes that this goal is shared by the therapist. Examples are provided (Davies, 1986; Eaton, in press) of how the therapeutic agenda is often re-defined by the therapist in line with the therapeutic model. The role of persuasive discourse and rhetoric are an extremely important part of this process. The arguments of psychotherapy critics which have been presented above suggest that it is the very intimacy of the therapeutic relationship that makes it a particularly powerful medium. Once a client feels safe in a trusting relationship they become much more vulnerable.

Post-modern approaches to the understanding of language, relationship and meaning provides a useful paradigm within which to explore dynamics of power. By considering the functions of language in a therapeutic encounter it is possible to access the many

⁴ In social constructionist terms this would be termed a set of discourses

levels of communication that are operating and the power-play that is enacted through language as the relationship develops. In particular, the work of Bakhtin on ‘the space between’ offered a promising vantage point from which to view the therapeutic relationship. The idea of a temporarily shared space in which two consciousnesses must meet and reach a state of shared meaning struck a chord and opened up ‘conditions of possibility’ for the research model.

Whether meaning is socially constructed or an essential truth inhabiting the dark recesses of the organismic self is not considered relevant to this research. In attempting to identify and understand the dynamic of power in a person-centred relationship the post-modern paradigm merely provided a useful lens. This research is based on an analysis of a therapy session and is grounded in practice. The aim is not to produce a new theory or even to add to the debates that already exist in the literature but fundamentally to offer practitioners some insight first into the importance of language in therapy and secondly into the nature of the power that exists within this relationship. Analysis of therapeutic discourse is a valuable therapeutic tool and may greatly enhance our practice of psychotherapy. Power is a feature of relationships, it cannot be eliminated and we cannot pretend that it does not exist but it does not have to be seen as evil. An understanding of the dynamics of power will help practitioners to learn how to work with it therapeutically.

Aims of Study

This study aims to:

Explore the dynamics of power within a person-centred therapeutic encounter using micro-analytic techniques to analyse conversational strategies and identify themes relating to notions of power.

3.0 Methodological Issues

3.1 Introduction

The aim of this chapter is to present a review of the techniques for analysing talk which have influenced the choice of methodology in this study. In considering an appropriate methodology for this research it was necessary to review the way in which talk has been analysed in the past. Methodologies in general reflect a particular theoretical, philosophical or political position. The analysis of therapy talk has been influenced by a range of traditions and philosophies each with their own methodological approach aimed at achieving support for their ontological position. Since the 1980s there has been a tremendous increase in the interest amongst researchers and clinicians in the basic science of listening and talking. The research revolution in this area was fuelled by the technological advances in recording equipment that enabled conversations to be taped and recorded in ways that captured speech and action that had not previously been possible and also for this data to be archived and analysed repeatedly (Morris & Chenail, 1995).

3.2 Conversation analysis and ethnomethodology

Ethnomethodology, although informed by philosophy, offers a ‘bottom-up’ approach to the study of talk, looking at the ordinary interactions of individuals and working up to a theoretical explanation of social processes. Garfinkel, (1967) criticised the notion that talk is about putting our thoughts into words in order to convey meaning to another. Meaning is shared through the process of negotiation and checking within a conversational interaction. A social relationship is created. The focus of both the ethnomethodology approach and conversation analysis was to observe and record speech in action with the view to understanding the detailed patterns and strategies used in speech. Talk is understood not in terms of the structure of language but through the

interactional organisation of social activities (Hutchby & Wooffitt, 1998). The analysis of conversation detaches talk from its author and its context in the sense that the focus is on the speech itself and how it is constructed in conversation. There are thus parallels between conversation analysis and deconstruction. However, unlike deconstructionists, conversation analysts see everyday talk as the basic form of interaction and therefore the preferred subject of study. There is an implication that a purity and homogeneity exist in this form of discourse which protect it from the impact of social and cultural influences.

Conversation analysis is a means developed by the ethnomethodologists to study the practices of social interaction. Goffman, (1955, 1981) had suggested that interaction can be treated in the same way as any other institution as it embodies the same moral and institutional order as, for example, the family or religion. Conversation analysis focuses on how people take turns in conversation, how overlaps and interruptions are negotiated, how conversations are opened and closed and so on. The conversation analytic study of institutional talk is also concerned with how the social worlds of the participants are evoked, manipulated and even transformed in conversation. In both cases the focus is on issues of meaning and context as embodied within sequences. Conversations are recorded using a detailed transcription notation which records not only speech itself but intonation, pitch, emphases, hesitations and often para-linguistic signals such as gestures and expressions too. Conversation analyses are simultaneously analyses of action, context management, and inter-subjectivity. When applied to an institution such as psychotherapy, Heritage, (1997) suggests the following structure for an analysis:

- Turn-taking organisation
- Overall structural organisation of the interaction
- Sequence organisation

- Turn design
- Lexical choice
- Epistemological and other forms of asymmetry.

3.3 Analysis of doctor-patient talk

A good example of the conversation analytic approach is the study of doctor-patient encounters carried out by Paul ten Have, (1989). He uses the notion of the ‘ideal sequence’ in a conversational interaction; a term first used by Jefferson & Lee (1981) who suggested that there is a potential in ordinary conversations for the interaction to follow an ideal sequence. This can be compared with Weber’s notion of ‘ideal type’. The basic stance is an ethnomethodological one in that it is proposed that it is through locally negotiated sequences of talk that institutions come into being. Ten Have applies these concepts to medical discourse. From analysis of doctor-patient sessions he proposes that an ideal sequence does exist. It comprises; opening, complaint, examination or test, diagnosis, treatment or advice, and closing. Deviations from the sequence occur when there is interactional asynchrony – misunderstandings of meaning or break down of the rules of interaction - which are often remedied as interaction continues. But, deviations can also be due to convergence of different formats. For example in the Jefferson and Lee paper they demonstrated how a troubles telling format clashed with a service encounter format – doctors treated description of symptoms as a service request and patients as an opportunity to engage in ‘troubles-telling’. Ten Have refers to Turner’s (1972) paper on ‘therapy talk’ which identifies its unique characteristics first as the refusal on the part of the therapist to answer requests for expert advice. Secondly, encouraging the client to express feelings and self interpretations – to become an expert on themselves through self understanding and reflection. However, the paradox, according to Turner, is that although the therapist appears to be abdicating their expert role and empowering the client to be responsible

for themselves they do not accept everything that the client says as equally relevant and valid. Thus there is a hidden element of therapist control which is not explicitly acknowledged, 'Thus 'therapy talk', while negating officially the difference in expertise between physician and patient, still confirms the expertness of the former and the dependence of the latter on his expert judgement'(ten Have, 1989:127). Ten Have's concern is with the form of conversation rather than its content.

Fairclough (1992) criticises conversation analysis for neglecting power as a factor in conversation but, as in the ten Have study it is often the case that power is recognised as having a role in social interactions but may be explicitly identified as the focus of study. In many conversations there is an asymmetrical distribution of rights and the discourse is part of the wider processes of social life, relationships and identities. For example, Labov and Fanshel (see below) also found that in therapeutic discourse certain styles are adopted by the client as a strategy to establish some parts of the text as immune from the intrusive expertise of the therapist (c.f. Goffman's notion of 'frames'). Fairclough criticises Labov and Fanshell for not providing a critical analysis of therapeutic discourse but agrees that they provide the appropriate analytic techniques for such a critique.

3.4 Microanalysis

Microanalysis is a form of conversation analysis which sets out to analyse the process of conversation in as much detail as possible. The techniques of microanalysis of talk are often traced to the Natural History of the Interview (NHI) (McQuown, 1971) project which ran from the 1950s –1970s in the USA. This was an interdisciplinary project involving psychiatrists, linguists and anthropologists in the microanalysis of interviews focusing on speech and action in taped interview situations. Labov and Fanshell's (1977) study is arguably the last example of this style of analysis. The majority of

psychotherapy process research uses this model whereby the process is broken down to its fundamental elements in order to understand the whole. This is explained by constructing theories and measuring devices that enable a reconstruction of the elements into an understandable whole. The result is the development of hundreds of theories to explain what is observed but as yet, no over-arching meta-theory that incorporates and explains everything that exists or could possibly exist. Theories and measures begin to determine what is observed and the way that it is made sense of. Labov and Fanshel's work is an example of this approach as are the studies collected in Greenberg and Pinshof's volume. The focus of the reconstructionist model is the measuring of micro-process variables e.g. verbal and non-verbal behaviour (Fast 1972) or therapist and client vocal quality (Rice & Kerr 1987).

3.5 Therapeutic discourse

Labov and Fanshell (1977) provide a good example of the use of microanalysis in their study of a psychotherapy encounter. They discovered that there was a great deal of implicit communication taking place in the form of unexpressed social and psychological propositions within the interaction and that most utterances could be seen as performing several speech acts simultaneously. They claimed that the participants in the interaction are understanding and reacting to these speech acts at many levels of abstraction. Thus they go beyond the analysis of sequences of communication, characteristic of conversation analysis, and explore the complex 'matrix of utterances and actions bound together by a web of understandings and reactions' (p.30). Labov and Fanshell recognise the uniqueness of the therapeutic discourse as distinct from everyday conversations in that the therapist as expert is able to exert power over the client's narrative. A consequence of this is that the client finds other ways to present themselves within the encounter to deal with the challenges of the therapist. This is referred to as

‘fields of discourse’ and in their study they identified three fields of discourse used by the client – everyday discourse, interview discourse and family discourse. Their analysis technique involved an expansion of the text which identified the use of client and therapist propositions, the fields of discourse used by the client and the way in which the interaction was managed . This technique provides the foundation for the analysis used in this research.

3.6 Discourse analysis and post-modernism

Although Labov and Fanshell’s study pre-dated the post-modern approaches to the analysis of therapy encounters it is similar in many ways to the examples of discourse analysis provided by later researchers. The difference is an epistemological one. For post-modern researchers claiming to work within a Foucauldian tradition the focus is on how meaning is constructed through discourse and participants are seen as being positioned by the discourses themselves. In this way talk is ‘de-constructed’ in order to reveal its functions within the interaction. For Foucault, discourses empower certain people who are able to appropriate the discourse and pronounce on the shape and form of the world. Within therapeutic discourse the therapist does just this through adopting the role of the expert. Discourse analysis is a technique to analyse the origins, nature and structure of the discursive themes by which the text has been produced. It is not a means to discover what a given text might mean to a thinking subject. The text provides an ontological map which frames our perception of the world. Discourse analysis provides a means by which to explore the operation of discourses of power within therapeutic encounters. Fairclough, (1992) criticised early attempts at synthesising language and social theory for neglecting the dynamic nature of power relations, ‘Little attention is paid to struggle and transformation in power relations and the role of language therein’ (p.54). Fairclough provides a technique for textual analysis which

aims to describe the larger scale organisational properties of interactions through the analysis of discursive strategies. In particular he identifies areas of control and symmetry through attention to control of agendas, exchange structures, formulations and evaluations of utterances. His notion of ethos provides a means to understand the construction of selves or social identities through discourse.

3.6.1 Social constructionism

In the 1980s a number of family systems researchers like Anderson and Goolishian (1988) moved from the cybernetic paradigm of family therapy based on seeing the family as a homeostatic system and individuals as information processing machines, to a hermeneutic model which focuses on the intersubjective loops of dialogue and the conception of the individual as a meaning generating device rather than the feedback loops of a system (Hoffman, 1992; Anderson & Goolishian, 1992). There has been a large amount of research generated within the field of family therapy. Social constructionist approaches (Mc Namee and Gergen, 1992; Shotter and Gergen, 1989) highlight language use and communicative practices that occur between as well as within people. These methods, based in a Foucauldian paradigm, enable a view of the construction of reality as contested and political. Within this paradigm Steven Kogan (1998) studied the way that client discourse is shaped and produced by therapist strategies. In particular he identified the strategy of ‘disciplining narrative’ by which therapists ‘mould client talk into a particular shape’ (p. 236). Certain client utterances are preferred within the therapeutic discourse and are privileged while others are marginalised.

3.6.2 Dialogue and rhetoric

There are many different approaches within the post-modern tradition aiming to marry the social context and the individual together. The approach of Mikhail Bakhtin

(1981) presented in the literature review is particularly relevant to the current study. If dialogue is perceived as a rhetorical act which occurs between (but belongs to neither) speaker and listener and exists in the boundary between the consciousnesses of each then there is a new way in which to analyse and understand the meaning of talk. Within this interactive gap meanings are transformed, commandeered and surrendered, just as the relationship itself evolves and changes. What can be uttered and what can be heard are determined by existing privileged discourses. Talk and relationship are inextricably bound together and any attempt to understand one must involve the other. In an analysis of a therapeutic encounter it is interesting to consider the way in which shared meaning is achieved (if at all) and the way that language can be appropriated by both the therapist and the client in order to gain control over that shared space. This shared space is boundaried by many discourses – language, social interaction, therapy, medicine, and so on and therefore what can be said is constrained.

3.7 Validity

The issue of validity within qualitative research is much debated within the research community and there is no consensus within the literature on how such research may be considered ‘valid’(e.g. Seale, 1999; Silverman, 1993; Denzin, 1997). Mischler (1990)states,

‘[N]o general, abstract rules can be provided for assessing levels of validity....These evaluations [of threats] depend, immediately, on the whole range of linguistic practices, social norms and contexts, assumptions and traditions that the rules had been designed to eliminate... ‘rules’ for proper research are not universally applicable [and] are modified by pragmatic considerations. (p.418; quoted in Searle, 1999, p.38).

The concept of validity is consistent with a modernist paradigm where if empirical research aims to provide evidence that increasingly approaches the ‘truth’ then this research must be shown to be objective and free from distraction. However, within phenomenological and post-modern paradigms where the emphasis is on

understanding the lived experience or the way in which individuals have made sense of their experiences then the question of how this can be shown to be valid raises fundamental issues concerning what is meant by validity and for what purpose the term is used and in what way it maintains its power. Validity itself is a discourse. This is not however to say that it is impossible to conduct and verify the quality of research and it is in the interests of the scientific community to consider both how quality research can be measured, monitored and maintained and also how the notion of validity is used as a discourse of power within the research community.

It is my aim to present my findings from this research as warranted; as a valid contribution to the literature and, as the product of a thorough and systematic research process. It is not my aim to present my findings as revealing a ‘truth’ about therapeutic communication and I do not claim an objective stance and therefore my validity criteria will not include those relating to truth value or neutrality (Lincoln and Guba, 1985). The emphasis is on depth of understanding and an opening up of possibilities and to this end I claim that my work demonstrates craftsmanship (Polkinghorne, 1983), transferability (Lincoln & Guba, 1985; Geertz), authenticity (Lincoln & Guba, 1985), methodological triangulation (Denzin, 1970) and generativity (Gergin, 1992).

3.7.1 Craftsmanship

This research represents a thorough and rigorous piece of work carried out with integrity. Decisions at all stages are supported and justified with reference to theory and literature and issues of validity are considered throughout with emphasis on trustworthiness, credibility and plausibility of the findings, (Kvale, 1996).

3.7.2 Transferability

The data in this study is drawn from a single example of a therapeutic encounter. In

this sense it represents a case-study approach and any claims for transferability of knowledge are concerned with contextuality and heterogeneity rather than a quest for universality through generalisation (Kvale, 1996). It is through the detailed and dense descriptions of the data that it is possible for comparisons to be made. Kennedy (1979) cites case law as an analogy. It is the responsibility of the receiver of the information to decide how a previous case (or study) may be a precedent for a current case. It is the researcher's responsibility to provide enough detail for these generalisations to be made. In this study this is achieved through the production of 'thick' description (Geertz, 1993). In other words enough information is provided in a multi-layered account to provide a rich and detailed understanding of the situation. This will enable transfer from one situation to another.

3.7.3 Authenticity

Lincoln and Guba (1989, 1994) added a fifth criterion of validity to their previous list of four which they referred to as 'authenticity'. This represented an acknowledgement that 'truth' can only be a temporary consensus of views. In order to be authentic within this research I have attempted to represent a range of realities, to provide a means to develop more sophisticated understandings of the therapeutic conversation, to enable readers to be aware of other perspectives and hopefully to generate some action toward further research and clinical application of my findings. Kvale (1996) refers to the application of knowledge as one of three legitimate validity criteria for qualitative research implying that a knowledge claim is valid if it has pragmatic value.

3.7.4 Methodological Triangulation

The traditional concept of triangulation is not compatible with the ethos of this work. A consensus across researchers or contexts sacrifices the individuality of the case for a

prioritisation of common elements. However, using a range of methodological approaches maintains the focus on the individual case and context but allows the possibility of a deeper exploration of the material. In this study a number of techniques are applied in the analysis of the data in order to provide a number of perspectives on the material.

3.7.5 Generativity

Validity is ultimately about whether the audience of the research can see new relations and ask new questions about the nature of knowledge as a result of the study (House, 1980). It is about how useful the research is in generating new ideas, theories , investigations or applications (Gergin, 1992) and it is in this area that I hope my study will succeed in providing a new avenue both for research and for practice.

Ultimately the whole issue of validity is immersed in questions of power. Who decides on appropriate truth claims? Who decides which research will be heard (funded)? Any claims I make regarding the validity of this research represent an example of persuasive rhetoric aimed at convincing my audience that my work is warranted because it meets certain agreed criteria. In this way the argument for validity reflects the subject of the research itself and presents a pleasing internal consistency.

3.8 Conclusion

The current study aimed to identify discourses of power within a therapeutic encounter and the methodology chosen reflects this aim. The methodology does not conform to one particular approach but adopts some of the techniques discussed above. In particular the techniques such as the identification of fields of discourse used by Labov and Fanshell offered a means to delve below the surface of the interaction and explore the

layers of meaning within the encounter. Fairclough's work on discursive strategies combined with Kogan's notion of disciplining narrative provided a means to unravel the way in which control is exercised within the encounter. The way in which language is constraining but is also used as a cultural tool (Bakhtin, 1981; Wertsch, 1998; de Certeau, 1984) underpins the thesis presented here that the client in this encounter resists the therapeutic agenda by 'going underground' in order to preserve his integrity.

4.0 Analysis Technique

4.1 Data Collection

The source of data for this analysis was a commercial VHS video-tape produced by the AACD entitled 'Carl Rogers Counsels an Individual on Anger and Hurt' featuring a 30 minute therapeutic session conducted by Dr Carl Rogers. The tape was made in 1973 and the client is a young black man who is currently in a state of remission from leukaemia. This is the second session of therapy. The tape was chosen firstly because it was considered important to use a session conducted by Rogers himself to explore the discourses of power in person-centred therapy and secondly because the fact that the client was young and black offered the possibility of more contextually based issues arising within the therapeutic encounter. The session is filmed using three camera angles. One positioned in front of both client and therapist which includes both participants in the shot. Another positioned behind the therapist which provides shots of the client alone and the third positioned behind the client which provides shots of the therapist alone. From time to time all cameras use the zoom facility to move closer in or further out from the subject. In this way the presentation of the session on the original film is a form of interpretation. The choice of camera shot has determined which parts of the visual data are recorded and which are not captured on camera. Thus, the 'raw data' is acknowledged to have been subjected to a selective process before the analysis begins and is not considered to be a representation of what occurred in the session. The video-tape was converted to digital format using Quick time™ movie software.

4.2 Transcription

'Transcripts are our constructions and making them is one of our central research practices' (Mischler, 1991: 277).

Transcription is the process by which speech is transformed into written text. It is the

entextualisation of speech. It is no longer believed that this is a representative process whereby the spoken word is transferred onto the page and meaning is preserved. Today the relationship between meaning and understanding is seen to be infinitely complex. Mischler (1991) argues that transcription is an interpretative process. Decisions regarding the format of the transcript, the choice of analytic unit, the inclusion or exclusion of intonation and pace of speech all influence the understanding of the speech itself. Thus, transcript formats support and reflect theoretical aims and serve a rhetorical function. So, it is acknowledged that the analytic process began with transcription and that the transcription process itself served certain functions relating to the aims of the study. The main premise of the study was that discourses of power were operating within this therapeutic interaction but were not necessarily apparent in the spoken text. Therefore it was necessary to explore meaning within both the ‘aesthetics of conversation’ (i.e. patterns, intonation, pitch etc. of speech : Tannen, 1990) and also within the behavioural gestures which may also reveal the emotional effects of the operation of these hypothesised discourses of power. The data was transcribed following the basic conversation analysis method (Jefferson, 1984) in an attempt to capture as much verbal and non-verbal detail as possible. Thus, hesitation, emphasis, expression and bodily gestures were recorded. Each speaker’s turn was taken as a coherent unit of analysis.

4.3 Analysis: Structure

The focus of this research is to identify and trace the influence of power within a therapeutic encounter through the analysis of language use and discursive practices. In order to do this methods employed in a range of other studies of therapeutic interactions have been combined in a way which is consistent with the ethos of the current study (Labov & Fanshell, 1977; Fairclough, 1992; ten Have, 1989; Kogan, 1998).

For the sake of this analysis four elements of the text were identified as relevant to the aims of the study:

- The Client's Story
- The Therapist's Story
- Management of Talk
- Parallel Process.

4.3.1 Sections 1 & 2

The first two sections focus on the stories brought to therapy by the client and the therapist respectively. The analysis sought to provide answers to the following questions:

- What are the themes of this story?
- How is the self presented in this story?
- How are discourses of power drawn upon in this story?
- What fields of discourse are employed by the protagonist in each story?
- What are the dominant paralinguistic signals used by the protagonist in this story?

The analysis technique used in these sections is based on that used by Labov & Fanshell (1977) in their microanalysis of a therapeutic session.

4.3.2 Section 3

The third section looks at the way that the interaction between the therapist and client is managed through discursive practices. The dynamics of the interaction are analysed with particular reference to strategies used to maintain power within the relationship and the impact of these strategies in the construction of meaning within the therapeutic session. The analytic techniques used here draw on Fairclough's,(1992) analysis of interactional rules in therapeutic discourse and Kogan's (1998) notion of disciplining narrative.

4.3.3 *Section 4*

The final section offers an alternative reading of the data in terms of analysing the text as a parallel process. Episodes are extracted from the text which demonstrate a further level of communication used by the client to promote his agenda in the session. The client's utterances are presented as having a dual meaning. A superficial statement relating to his 'everyday' discourse but also a deeper meaning in terms of his feelings about the therapeutic relationship itself and its parallels to his life experience which cannot be expressed overtly in the session. This section is influenced by the notions of language as a mediating device between individuals where each aims to appropriate its use in order to have their voices heard (Bakhtin, 1981; Wertsch, 1998; Rommetweit, 1974; De Certeau, 1984). The space between client and therapist is a space that is temporarily shared for the purpose of the session and both client and therapist attempt through their use of language to colonise this space. The discourse is then seen as a battle in which each participant is attempting to be heard. As the client is positioned as 'powerless' in relation to the therapist he must appropriate language through the use of 'guerilla tactics' in order to preserve the integrity of his self, (de Certeau, 1984). The analysis indicates episodes where the client's utterances can be read on two levels.

5.0 Analysis

5.1: The Therapist's Story

In this therapeutic encounter the therapist comes equipped with a framework and structure within which the session is understood and constructed. The themes which appear in the therapist's utterances represent the 'story' or 'context' or 'consciousness' (Bakhtin,1981) from which he is seeking to reach out and connect with the client. In this case, the therapist adheres very closely to a therapeutic agenda throughout and the therapist's story is almost synonymous with the therapeutic discourse.

5.1.1 *Narrative themes*

The major therapist theme identified in this text corresponds to one of the four general therapeutic propositions identified by Labov and Fanshell (1977) in their study of a therapeutic encounter. It is illustrated below with examples from the text.

5.1.1.1 *The client should be in touch with his emotions*

The majority of the therapist interventions in this episode refer to emotions. At the beginning of the session the therapist explicitly states the therapeutic agenda in the form of a reflection of the client's previous utterance,

2.55 =You'd like to get in touch with whats going on in [you] =

The initial focus of the therapist is on the client's anger and his resistance to expressing this anger,

2.23 There's some real anger there ((nodding)).

6.53 Yeah mm and eh (2) so I hear you explaining and explaining (2) that eh 'its not my nature to be angry its just that I am angry right now'((hesitation, looking down))

A connection is then made by the therapist between hurt and anger,

9.18 =Perhaps at a deeper level you're afraid of the hurt you may experience if you let yourself experience the anger

10.12 I really do get that that this realisation that ma:ybe what I'm most afraid of is the hurt that I might experience(2) em (1) makes you more ((hand gesture)) (1) cautious about whether you should or could really let go of the of the anger ((slow nodding, slow pace))

Although acknowledging the client's difficulty in expressing the emotion the therapist persists with this narrative by exploring why the client may find this difficult in relation to his fear of dependence and admission of defeat,

11.00 To show it ((hand gesture)) and I guess to let yourself sort of (3) experience it that (3) that I guess ((nodding)) would be difficult (2).

11.58 Suppose I really expose to somebody the fact that I'm (1) deeply, deeply hurt, that in a sense would be comparable to (.) having to be dependent on someone when you can't walk or something like that?

14.08 You don't want to say 'I really was defeated (1) at times' and yet ((shaking head)) that's the truth

15.49 Something really awful about showing, letting anyone know that 'I'm hurt,=

17.47 A big lump of hurt though=

18.02 and how to let that hurt come out in the open ((hand gesture)) how to let it (4) emerge and be out here instead of way down locked in here

Towards the end of the session the client is asked to think about the behavioural expression of the emotion,

21.45 [That's what I was thinking] I was just thinking if you could only cry=

22.00 but I guess you're saying there are times when you have that lump in your throat and you sure as hell feel like crying

22.39 I feel that(.) also you're afraid of crying for yourself (3)

23.50 It was better than (.) never letting anyone see you cry=

24.27 but the sorrow is still there=

5.1.2 Presentation of the self

The therapist's narrative reveals little about his own sense of self. The image that is presented conforms to the discourse of the therapeutic relationship. He is playing the role of the person-centred therapist and little is revealed about the individual himself.

The following examples demonstrate features of the therapist image or role.

5.1.2.1 I am listening and trying to understand

The therapist listens carefully to the client's story and checks out his understanding,

1.07 I've thought a lot about what you had to say about that

3.39 Let me see if I understand that.

He is demonstrating appropriate therapeutic skills consistent with the model and presenting as a caring facilitator as the client engages with a process of self exploration.

5.1.2.2 I can spot your attempts to resist

However, the examples of challenging within the text indicate that the therapist's role is also to maintain some control over the process. When the client deviates from the therapeutic agenda he intervenes with a challenge,

6.05 That's what I sense is going on now

6.53 Yeah, em and ((looking down)) eh (2) so I hear you explaining

5.1.2.3 I have some insight into your situation

The therapist also presents himself as someone with a deeper level of insight or knowledge.

9.18 =Perhaps at a deeper level you're afraid of the hurt..

14.08 You don't want to say 'I really was defeated (1) at times' and yet((shaking head)) that's the truth

5.1.3 Discourses of power

Within the text the therapist draws on a number of discourses of power. In some instances this is a denial of power as in the first example, in others it is a more subtle use of therapeutic strategies which reveal the inherent imbalance of power in the relationship.

The first theme relating to power in the text corresponds with another general therapeutic proposition, identified by Labov and Fanshell (1977),

5.1.3.1 The therapist does not tell the client what to do

The principal of a non-directive stance is fundamental to the person-centred model as articulated by Rogers as 'following the client'. The model draws upon a discourse of power equality between client and therapist. The session opens with Rogers offering control of the agenda to the client,

00.52 OK.(2.2) where do you want to start this morning?

Using interventions such as reflection and summarising and making empathic responses allows the therapist to create a nurturing environment for the client and an impression of mutuality. In the latter half of the session the therapist responds to the client's challenge to provide more direction by using irony,

18.42 Sure, it'd be awfully nice if somebody could say now if you do this and this (.) all ((hand gesture)) your hurt will come out a:nd it'll be gone for ever.

5.1.3.2 The therapist can give permission

The text includes an episode where the therapist gives his permission to the client.

8.05 (1)((looking down)) I get what you're saying and I also feel quite strongly that I want to say (2) its OK((nodding emphatically))with me if you're angry here

8.21 I'm just saying its OK with me (2) if you feel like being angry you can be angry

Such a discourse positions the therapist in a more powerful position than the client.

5.1.3.3 The therapist is the expert

The text reveals a departure from the person-centred discourse on a number of occasions where the therapist offers an interpretation of the client's position. However the interpretation is couched in the person-centred narrative style and offered as a tentative hypothesis.

6.05 That's what I sense is going on (.) now that you feel (.) 'theres so many reasons why I really shouldn't eh express my anger I'll, (shaking head) I'll talk about all those reasons' (smiles)

10.12 I really do get that that this realisation that ma:ybe what I'm most afraid of is the hurt that I might experience(2) em (1) makes you more ((hand gesture)) (1) cautious about whether you should or could really let go of the of the anger

Such a discourse again creates an imbalance of power by positioning the therapist in the role of expert.

5.1.3.4 Talking as the client

An unusual narrative style can be identified in the speech acts of the therapist which again indicates a power imbalance in the relationship. This is where the therapist talks as though he were the client using the personal pronoun, 'I' to refer to the client,

10.16 that ma:ybe what I'm most afraid of is the hurt that I might experience(2)

11.58 Suppose I really expose to somebody the fact that I'm (1) deeply, deeply hurt, that in a sense

would be comparable to (.) having to be dependent on someone when you can't walk or something like that? ((Hand gestures))

14.08 I really was defeated (1) at times

15.54 =I'm hurting

However this strategy of speaking as the client is also a means of colonising the client's individual sense of self. The therapist has now subsumed the client into himself by speaking for him – a powerful invasive strategy.

5.1.4 *Fields of discourse*

The text reveals two main narrative styles within the therapist's speech.

5.1.4.1 *Interview style*

The first is that identified by Labov and Fanshell (1977) as the 'interview style' field of discourse characteristic of therapeutic discourse. This is characterised by the use of vocabulary in a specialist way that differs from everyday discourse and the discussion of emotions rather than the expression of them.

2.54 =You'd like to get in touch with whats going on in [you] =

Here the style of the narrative belies the therapeutic assumptions regarding an inner world which must be brought into awareness for psychological health to ensue.

9.18 =Perhaps at a deeper level you're afraid of the hurt you may experience if you let yourself experience the anger

This quotation illustrates both the therapeutic vocabulary of 'deeper' levels and also the discussion topic of emotion which, as has been demonstrated above, dominates the therapist's interventions in this text.

The therapist only occasionally offers evidence of felt emotion in the form of discomfort or slight anxiety,

Here, for example accompanying a challenge,

8.05 (1)((looking down)) I get what you're saying and I also feel quite strongly that I want to say (2) its OK((nodding emphatically))with me if you're angry here ((intake of breath))

the therapist avoids eye contact with the client, makes a sharp intake of breath and nods emphatically. However there is a much lower incidence of therapist emotion evidenced in the text than client emotion.

5.1.4.2 Person-centred style

The second narrative style is labelled a ‘person-centred’ narrative style because it is defined by the use of skills associated with the core conditions of the therapeutic relationship – empathy, genuineness and acceptance. For example acceptance right at the beginning of the session,

1.07 =I’ve thought a lot about what you had to say about that [mm]

and all three in the following utterance,

8.05 ((looking down)) I get what you’re saying and I also feel quite strongly that I want to say (2) its OK((nodding emphatically))with me if you’re angry here

The use of phrases such as ‘I think I get that’ (2.11), ‘That’s what I was thinking’(21.46), ‘Let me see if I understand’ (3.38), ‘That’s what I sense is going on’(6.05), ‘so I hear you..’ (6.51), ‘I get what you’re saying’ (8.04) all indicate the presence of the person-centred narrative style in the text.

5.1.5 Paralinguistic signals

Throughout the session the therapist maintains a physical stillness which contrasts markedly with the movements of the client. However a number of consistently used non-verbal cues provide markers for particular discourses in the therapist’s story.

5.1.5.1 Signs of Unease – hesitation, touching head, avoidance of eye contact

For example, the avoidance of eye contact and the hesitation accompany the therapist’s speech when challenging the client,

6.53 R Yeah mm and eh (2) so I hear you explaining and explaining (2) that eh ‘its not my nature to be angry its just that I am angry right now’((hesitation, looking down))

5.1.5.2 Staring

The therapist stares at the client during the two long periods of silence in the session which could be interpreted as a threatening gesture adding to the client’s sense of

unease and positioning the therapist again in a position of power.

5.1.5.3 Nodding

The client's acceptance of the therapeutic agenda is accompanied by vigorous nodding by the therapist as a form of reinforcement,

5.55 C and at the same time y'know (.) I really haven't had the opportunity to let anybody accept mine. (.) or maybe I haven't given it to them but =

6.02 R =Yeah or maybe you haven't given it to them= ((emphatic nodding))

In this example the therapist repeats the client's words which reinforce his sense of agency. The nodding serves to underline this reinforcement further.

5.2 Section 2: The Client's Story

The text is analysed with reference to the client's story, identifying the narrative themes, presentation of self, discourses of power, fields of discourse and paralinguistic signals.

Unlike the therapist's story which is univocal with a coherence and central theme, the client's story is fragmented, partial and disorganised.

5.2.1 *Narrative themes*

As noted in the biographical details, this client is a young black man currently in a state of remission from leukaemia. He presents as an articulate and reflective client and is presenting a story based around his attempt to make sense of his life. Having faced death it is understandable that the client is reviewing his life and engaging in a search for meaning,

25.24 ...really wanted that to be for a some kind of a higher level, some kind of a cause y'know (1) but not to h:ave that em (2) to see anything, any benefit that I did (.) y'know all of that work I mean hours and hours and (.) ((looks down, shakes head))

Within this search for meaning there are a number of specific themes which are presented below.

5.2.1.1 *Anger and hurt about what happened*

The client conforms to the therapeutic agenda by discussing the themes of anger and hurt

within the text. The origins of his distress stem from his treatment by the society in which he lives which has caused him even more suffering than the physical pain of the leukaemia,

4.09 and to some extent that kind of leukaemia that kind of (.) deterioration of the body is the same kind of thing that happened to my [mind] (nod)

Although admitting that he is angry and hurt,

8.51((looking down)) I'm not sure how to respond to that at all (2) y'know (.) because a part of that anger is all the hurt and maybe if I maybe ((looking up)) what's happening is that if I become angry and I really let it hang out (.) that I really will see how hurt I [am] (1) and em,

he is frightened to let himself get in touch with this,

10.44...its aa (2) I guess I would be and I I'd really admit openly I'd been hurt I I said (2) that I've that I've been hurt and I think you know that I feel I've been hurt but (2) to really show that y'know

and is not convinced that there would be much value in this,

14.32 I don't know if there's any value in (2) y'know maybe to myself admitting it to myself or whatever

The client's focus is on himself as part of society and dealing with his problems as a social being.

5.2.1.2 *Mixed messages*

This theme operates at many levels in this text but for the purposes of the client's story he refers to the messages that he has received from others who say one thing to his face but another behind his back, suggesting that he is not accepted,

7.24 Y'know if people send out certain messages (eye contact)(1) and no no matter what they're saying or whatever there are certain kinds of messages that I'm getting (.) y'know. They're saying that hey y'know that that isn't for me kind of thing (.) y'know.

The effect of which is that finds it difficult to trust others.

3.00 For sure (3) I think that I could probably trust that (.) a lot better than than trusting what's happening or what has [happened],

When talking about his father-in-law towards the end of the session the theme recurs,

28.26 because he was straighter with me than a lot of people

In fact the session actually ends on this theme,

29.14 Smiles and polite kisses and things like that y'know (1) that is (1) y'know part of the hurt y'know I'd rather for somebody to say y'know I think you're a lousy SOB or whatever as opposed to saying "hello dear how are you ?" y'know, y'know?

5.2.1.3 Need to be constructive

For the client there is a moral discourse running through his speech relating to his desire to be productive, to achieve something to make things better. In dealing with his anger and hurt he wants to find a constructive way to do that,

7.02 For sure ((laugh)) for sure (.) and I try ((shaking head)) to be angry in a productive way I don't know how (eye contact) you be angry in a productive way y'know?

For him, expressing his anger would only be helpful if it was productive. Although angry and hurt the client has a desire to put things right in a positive way. Although rejected by his own society he wants to be accepting and forgiving of those who have done him wrong. In the following utterance he uses the interesting metaphor of 'sickness' paralleling his own physical sickness,

5.28 mm (.) but how do you blame somebody else's sick. (.) y'know (.) and I think that people that do that ((hand gesture)) to other people or at least the one who was done to me ((pointing to chest)) em they're really sick you know (.) and here I am y'know (1) trying to y'know I don't know if its forgiving, I don't know if I'm sounding confused or whatever (.) may (1.5) y'know (.) but (1) trying to accept their sickness (.) y'know

Again in this example he uses the word alienating, not to describe how he, himself, feels but how he would like to avoid doing that to others. These are examples of a form of projection within the text.

7.38 and as befo:re I'd like to work with th:at and like to try to communicate without alienating (.) people or whatever

5.2.1.4 Need to get something back: reciprocity, mutuality, value

As the session progresses the client develops the theme of reciprocity and mutuality. He draws on a social discourse of justice – the belief that work will be rewarded and one has a right to equality. This can be read on many levels and will be addressed again in

section 4 but for the purpose of this section it is considered as a theme in the client's story.

15.06 and in a way I like to be loved too I like to be (1) some reciprocity.

After a 6 minute silence he continues with,

15.20 and I'm going to start I think expecting that (1) without being cold or anything like that but I have to (.) y'know start getting something back in return

The client feels that he has worked hard but it has not been worth anything,

25.32 but not to have that em (2) to see anything, any benefit that I did (.) y'know all of that work I mean hours and hours and (.) ((looks down, shakes head)) its just incredible and I think th:at would be one y'know I was saying dammit ((lifts hands)) why in hell did I spend so much time (.) why did I spend so much time y'know the leukaemia t:he everything that happened to me or whatever would be properly deserved if one person (.) life would've been changed or something y'know and like (.) and maybe it has or whatever but I think that I don't trust that its been worth it you see

Here he is again drawing on amoral discourse of justice.

Finally the session ends with the echo of this theme,

29.03 or at least my being able to see that that it wasn't true, it wasn't real, I wasn't getting anything back I wasn't getting anything, any nourishment y'know ()

5.2.2 Presentation of the self

A strong theme in the client's narrative is his reflection on his sense of self. This is not a multivocal and contradictory theme but includes the following aspects.

5.2.2.1 Fragmented

The examples below demonstrate the client's sense of different parts of himself,

1.31 I guess my (3) ((looking away)) my er mind ((pointing to head)) er academically or something y'know something other than emotion

4.33 and I guess that part of me (.) thats my culture and its a part of the total is saying that its not all that good to be angry (.) y'know'

He also draws on social discourses to position himself within his race and gender,

4.52 when blacks become angry they're not angry they're militant

15.56 Sure (.) ((looking down)) sure its (1) y'know it has something to do with being a man, it has something to do with (.) with the race ((eye contact)) thing, y'know

In this way he brings the social and political context into his story.

5.2.2.2 Agent

The client presents himself both as an autonomous agent taking charge of his life and

being certain about what he wants. He is trying to forgive and accept others,

5.38 and here I am y'know (1) trying to y'know I don't know if its forgiving, I don't know if I'm sounding confused or whatever (.) may (1.5) y'know (.) but (1) trying to accept their sickness (.) y'know

and behave in a productive way,

7.08 and I try ((shaking head)) to be angry in a productive way and like to try to communicate without alienating (.) people or

He accepts responsibility for the fact that others have not accepted him,

5.55 and at the same time y'know (.) I really haven't had the opportunity to let anybody accept mine. (.) or maybe I haven't given it to them but =

5.56

Anger is not part of his self concept,

6.49 =but its not my nature to be angry

but he wants to be loved in return,

15.09 I like to be loved too

5.2.2.3 *Victim*

The victim discourse recurs throughout this analysis and is difficult to place definitively within the structure. In terms of the client's presentation of himself within the text there is a construction of himself as a victim but also a resistance to admitting this to himself,

14.08 Y'know (.) and I really don't want I really don't want anybody historically to have gotten the best of me but they did, they did, they beat the hell out of me ((camera focus on client wringing hands))

5.2.3 *Discourses of power*

Any relationship including a therapeutic one involves a dynamic of power. One participant may be perceived as more powerful than the other in terms of his status or role but both participants draw on various discourses of power throughout the interaction. In this text the client presents himself as an autonomous agent as was shown above, he uses discursive strategies such as resistance to exercise his power as will be shown in the next section and he draws on a number of discourses of power within his story. However the client's story at the surface level presents the client as powerless.

5.2.3.1 *Powerless*

The client acknowledges the power differential in the relationship and the implicit rules governing the interaction a number of times,

1.11 I'm not sure ((looking away)) if ang:er (.) being angry now is ((eye contact)) a (.) part of the process and I've got to do that

He is unsure of the process and is aware that there is some compunction on him to behave in a certain way.

He again alludes to the power of the relationship later in the session,

12.31 I feel that I feel like I have to express that that hurt or whatever

And later,

20.02 I don't know if I have any control ((smiling)) over that ((shifts back and forth in seat)).

He also positions the therapist in the role of expert,

6.39 I'm sure you know that ((looks down))(.) there's a lot of anger there=

10.55... I think you know that I feel I've been hurt but(2) to really show that y'know

18.51 I have a suspicion that maybe you know ((reaching for water)) somethings that I don't know ((laugh)).

The client positions himself as a victim of the system and of others,

1.54...it almost seems like that (1) ((looks down)) whatever is ha:ppening in my environment or whatever happened in my environment is pulling me into, again (1.5) aah that kind of a trap((eye contact)) that kind of a system that (.) I don't particularly ca:re (2) y'know ((shaking head)) if you know what I mean.

The client here does not see himself as having any control over his environment, he is powerless.

The theme of being trapped is echoed again where the client describes the lack of choice available in the adoption of moral stances,

2.27 Its, its almost like in this co:untry- ((looks away)) (1) and, and I've always felt like this you only have about two ((eye contact)) options, y'know when you deal with race-(2) eh you either have to b:e (1) you're either a racist- or you're an anti-racist.

2.28

And again when refering to the process of social conditioning,

22.58 y'know we're (.) just being so conditioned not to y'know from a little thing of oh y'know little little men or big boys or whatever don't cry and (1) and

5.2.4 *Fields of discourse*

The client uses a number of narrative styles within the text.

5.2.4.1 *Therapeutic discourse*

The main therapeutic discourse in this session is the importance of the client accessing his emotions, particularly anger. The client does not get in touch with emotion during the session but does conform to the agenda by articulating his thoughts about his emotions. When asked by the therapist to choose where to begin he volunteers the therapeutic agenda,

00.57 I don't know, I was thinking that (1.2) when we talked earlier about the the anger (.) I've been thinking a great deal about that =

Throughout the session he both conforms to and resists the agenda in so far as he accepts that he feels angry and hurt but he also presents reasons why he cannot get in touch with these feelings. The resistance is often mitigated by humour as in this episode a little later in the session,

6.19 Yeah (laughing) for sure (laughs, moves position) (2) I don't know really (1) y'know (.) if (2)(claps hands on legs) maybe I'll just be angry one day (laughing) and maybe I'll really feel better or whatever y'know and and When I smile I'm aah (3) y'know (lifts hand) I'm smiling but (.) there's a a lot of (.) I'm sure you know that (looks down) (.) theres a lot of anger there=

6.49 =but its not my nature to be angry (5)

R yeah

C its not my nature to be angry but I feel angry

The client again conforms to the therapeutic agenda when after a long period of silence he makes the connection between hurt and anger,

8.51 C ((looking down)) I'm not sure how to respond to that at all (2) y'know (.) because a part of that anger is all the hurt and maybe if I maybe ((looking up)) whats happening is that if I become angry and I re:ally let it hang out (.) that I really will see how hurt I [am] (1) a:nd em

5.2.4.2 *Making Sense*

The text reveals a characteristic style used by the client where he reflects on his experiences in order to make some meaning for himself. This style is often marked by the phrase, 'it almost seems like' as in the first example at the beginning of the session,

1.54 C((nodding))=For sure, it almost seems like that (1) ((looks down)) whatever is ha:ppening in my environment or whatever happened in my environment is pulling me into, again (1.5) aah that kind of a trap((eye contact)) that kind of a system that (.) I don't particularly ca:re (2) y'know ((shaking head)) if you know what I mean.

And again,

2.27 C Its, its almost like in this co:untry- ((looks away)) (1) and, and I've always felt like this you only have about two ((eye contact)) options, y'know when you deal with race-(2) eh you either have to b:e (1) you're either a racist- or you're an anti-racist.

5.2.4.3 *Process*

The text is interspersed with comments about the process itself, the 'here and now' and the relationship with the therapist. For example at the beginning of the session the client comments on his lack of knowledge about the process itself,

1.11 C and I'm not sure ((looking away)) if ang:er (.) being angry now is ((eye contact)) a (.) part of the process and I've got to do that ((shuffling))

8.16 y'know its hard to know((looking away)) how to be angry y'know?

8.51 I'm not sure how to respond to that at all

9.12 y'know that just came to me as you were talking

5.2.5 *Paralinguistic signals*

The client's non-verbal behaviour provides much additional information regarding the important aspects of his story. He uses certain characteristic gestures and expressions and also ubiquitous verbal tags. Metaphors and mitigating devices are also employed by the client.

5.2.5.1 *Mitigating – humour*

The client uses humour to relieve tension. It occurs after a challenge for example he makes a joke after the therapist challenges his avoidance of emotion,

6.26 maybe I'll just be angry one day ((laughing))

and again after the therapist has challenged him to cry,

21.48 Yeah, if you ((laughing, looking left, shuffling)) but thats a trip y'know thats a trip like eh ((shrug))

It also serves to cement the relationship with the therapist when a joke is shared. For example the client explains that , 'when blacks become angry they're not angry they're militant (4.51) which is followed by a laugh and the therapist shares the laughter with the client (4.56).

5.2.5.2 Metaphor

A number of examples of metaphor occur in the text. As with humour they are most common in situations of tension. For example

16.41 I don't know how to get that up at all ((laughing, drinking water)) Everytime I get close to that I take a drink of water.

The metaphor of using water to keep the hurt from coming up is used to avoid the pain of discussing the difficulties in confronting this pain.

A little later the metaphor of the cookbook is used to mitigate the expressed desire for the process to be less challenging – if only there were a recipe to follow,

18.13 Right. ((laugh)) (4) yeah (3) y'know I I never believe in cookbook answers (.) to anything ((shrugging)) even when I cook I don't use a cookbook I just don't believe in it (.) but em I'd really like (.) to be able for someone to tell m:e to y'know maybe how to do that in about five minutes and be through like the rest of my life in peace(.)

This serves its purpose as the therapist laughs and joins in with the humour.

5.2.5.3 Verbal tags

Many of the client's utterances begin with 'I'm not sure' or 'I don't know'. This is an example of what Fairclough (1992) calls negative politeness. It is also a submissive format suggesting that the client is not confident about his position in this relationship.

He is again mitigated his utterance by sending the signal that he is only guessing, is not confident may be wrong etc.

5.44 I don't know if its forgiving, I don't know if I'm sounding confused

5.2.5.4 Signs of distress

The client's verbal communication is accompanied by non-verbal signs of distress particularly evident during the periods of silence. They include, avoidance of eye contact, hand wringing, displacement activity such as drinking the water, looking away, hesitations, shuffling, shrugging. For example in this utterance the client is getting close to his feelings of hurt and the utterance is followed by a 14 second silence.

9.27 (2) Really (laugh) em((moving position)) (6) I keep getting these blo:cks y'know these y'know (.) when I come to something like that y'know because (.) y'know to me thats a revelation and I'm not really sure that em (4) risking being angry ((shaking head)) I guess or something like that y'know ((smiling))(2) losing control maybe

5.3 Section 3: Management of Talk

‘...discursive practices are ideologically invested in so far as they incorporate significations which contribute to sustaining or restructuring power relations’ (Fairclough 1992: 91).

Within this section the aim of the analysis is to identify the discursive strategies used by therapist and client to manage the relationship and the therapeutic agenda. In the previous two sections it has been shown that the therapist and client are entering this relationship with different stories. For the therapist the therapeutic agenda comprises defining the problem as the client’s lack of awareness of his real self and the aim of therapy is to facilitate the client to get in touch with his emotions. However, for the client the problem is a sense of meaninglessness and futility about his life and his agenda for the therapy is to find a way to make sense of his life and the suffering that he has endured within a social and political context where the theme of justice provides a framework to his understanding. Therefore the therapeutic encounter begins with two different definitions of the problem and two different agendas and the ensuing interchange is presented here as a battle for control over this agenda using subtle strategies of control and resistance.

The analysis does not rigidly conform to the approach of the conversation analysts in their micro-analysis of the linguistic content of conversation, neither does it conform totally to the post-structuralists’ techniques of discourse analysis used to understand the function of language in creating meaning and positioning individuals within social discourses. Rather, this analysis combines elements of both these approaches in an effort to discover how each participant in the conversation attempts to use language and paralinguistic signals to manage the therapeutic process.

The following discursive strategies have been identified within the text through the

established process of immersion in the data and continual re-reading of the text and viewing the tape. Fairclough's (1992) analytical techniques based on rules of interactions and those of Kogan (1998) on disciplining narrative have been adopted where relevant. The strategies identified below and the functions they serve within the discourse are presented not as definitive but rather as an example of some of the discursive strategies used in this session

Some strategies are employed solely by one participant while others are used by both client and therapist.

5.3.1 Asking direct questions

'But questions are a form of control, in that they steer the other person heavily toward answering what they want to hear, rather than to what they might have been about to tell you' (Houston 1995: 7).

The therapist asks few direct questions in this session as is consistent with the therapeutic model. The questions which he does ask sit within the person-centred therapeutic discourse and serve the function of communicating empathy and positive regard to the client. As can be seen these interventions are successful in maintaining the therapeutic relationship as the client responds from within a therapeutic discourse.

Example 1

The session begins with the therapist inviting the client to take the floor:

0.52 OK,(2.2) where do you want to start this morning?((leaning forward, shuffling into comfortable position))

The client responds initially with 'I don't know...' but then proceeds to present an appropriate therapeutic theme – anger. The possible answers to the question are constrained by the rules of therapeutic discourse and the client demonstrates his awareness of this in his answer (Parker 1999, Foucault, 1980).

0.57 I don't know, I was thinking that (1.2) when we talked earlier about the the anger (.) I've been thinking a great deal about that =(smiles))
((Rogers nodding at mention of 'anger'))

He makes a link with the previous session and thereby creates an acceptable therapeutic agenda and context and is reinforced by the therapist's non-verbal communication.

Example 2

Having listened to the client's further attempt at agenda setting where he explains that the leukaemia is not really the focus of his distress but that it is his treatment by others that has caused his feelings of hurt, the therapist presents the client with a clarification and asks if he has understood correctly.

3.39 Let me see if I understand that that you feel as though (.) em (2) what the culture and people and so on have, have done ((pushing hands away))_ to you has really caused you more suffering than the leukaemia is that what you're saying?

The therapist is following the client and checking that his understanding is correct. It serves the function of demonstrating respect for the client and humility on the part of the therapist. The client respond with 'I think so (.) I think so(.) ((maintaining eye contact))' (3.51) and continues to explore his theme. The holding of gaze here indicates the effectiveness of the therapist intervention in maintaining the client's trust.

However, the questioning strategy is used by the therapist in a more subtle way in the next example. Here his strategy functions to discipline the client's narrative (Kogan, 1998)

Example3

Following the client's story about black men being stereotyped as militant rather than angry the therapist again uses clarification to demonstrate empathy. Although on the surface the question is an hypothesis - did you feel labelled by this experience? And again conforms to the therapeutic discourse, the term 'label' had not been used by the client but had only been used previously (2.57) by the therapist. Therefore he is following through a theme that he himself introduced and offers a reformulation of the client's story (Davies, 1986).

4.57 Another label?

The client responds by avoiding eye contact but verbally agreeing with the therapist, 4.58 mm for sure, for sure (.) for sure (1.5) and I kee.. ((Looks down))

He then performs a narrative shift and introduces the new themes of blame and revenge (Sluzki, 1992).

Example 4

The therapist's consistency seems to break down when towards the end of the session he uses a direct question,

25.03 If you did cry what would some of the themes of that crying be?

In the preceding utterance the client has talked emotionally about the sorrow that he feels and his difficulty in knowing how to deal with it but the therapist's question seems to come out of the blue and is followed by a period of silence before the client responds with his regrets about trying to improve himself at the cost of not seeing his children.

This strategy does not seem to follow the person-centred discourse to the same extent as the previous examples and does not serve a relationship building function. If anything there is a drop in empathy as a result.

The client also asks few direct questions in the session.

Example 1

Throughout the session the client's speech is peppered with discursive tags the most prominent of which is 'do you know what I mean? And the truncated 'y'know?' The client is looking for understanding from the therapist. He wants to present his story in such a way that it can be understood but he is aware that there is a divide of culture, race, status etc, which has to be bridged. He is checking that the therapist is with him and the accompanying para-linguistic markers (eye contact and a questioning look) signal both the importance of this to the client and also his tentativeness. The tag 'y'know what I mean?' is more evident in the early parts of the session where the client is drawing the boundaries around his agenda in the form of what he does not want to

do and also placing the theme of race on the agenda,

2.06 I don't particularly care (2) y'know ((shaking head, questioning)) if you know what I mean.

2.37 That doesn't really seem to be the kind of thing that I (1) I y'know I don't really care to be an anti-racist if y'know what I mean? (.) anymore (1)

4.52 y'know when blacks become angry they're not angry they're militant (2.5)

R mmhmm

C y'know what I mean?((laughing, looking down))

Later in the session the tag is again used to emphasise the seriousness of the client's point – it is not so much 'do you know what I mean' but more 'I really mean this' accompanied by intense eye contact.

In the next example the utterance comes at the end of a challenging episode where the client and therapist have been engaged in a discussion around the client's experience of his hurt. This is a heart felt wish from the client for the process not to be painful but mitigated as always by humour.

18.28 em I'd really like (.) to be able for somebody to tell me to y'know maybe how to do that in about five minutes and be through like the rest of my life

R ((laughs))

C = y'know what I mean? ((maintains eye contact))

In this final example the utterance is almost a warning mitigated by the third person narrative.

20.40 Yeah, yeah and my friend said y'know one of these days, ((looking left)) he says if you (.) if you don't get it together, or something he says, not if you don't get it together, but y'know one of these days you're just going to really ((eye contact)) lose it (.) y'know, y'know what I mean?

Example 2

The most direct question asked by the client comes after the episode (8 minutes into the session) when the therapist challenges the client's avoidance of the therapeutic agenda.

The therapist has just repeated his permission for the client to be angry in the session and the client eventually responds with,

8.26 You really believe that? ((smiling, quizzical look))

It constitutes a reciprocal challenge to the therapist but is ambiguous as it may be checking the therapist's honesty or it may be irony as in 'you can't really believe that'.

It is followed by the first long silence of the session lasting 18 seconds.

5.3.2. *Reflection*

In the person-centred approach reflecting feeling back to the client is seen as a demonstration of empathy. Reflection is a common intervention used by the therapist within this session and serves a variety of purposes. As a person-centred strategy it appears to allow the therapist to keep close to the sense of the client's words and avoid the possibility of imposing an interpretation. However some of the client's story is reflected back while other parts are not; this choice belongs to the therapist and, it is argued, is a strategy by which the therapist reconstructs the client's story and shapes the client to stay within the therapeutic discourse.

Kogan (1998) uses the phrase 'disciplining narrative' to describe a conversational strategy used by therapists to mould client's utterances toward a normative centre. The notion follows Foucault's concept of normative power (Foucault, 1979) and functions to privilege particular client discourses and marginalise others. In this session the preferred narratives are illustrated below.

The first example shows how self agency is privileged over accounts of external, social and cultural narratives.

Example 1

5.55 C and at the same time y'know (.) I really haven't had the opportunity to let anybody accept mine. (.)
or maybe I haven't given it to them but =

R =Yeah or maybe you haven't given it to them= ((emphatic nodding))

Here the client ends his exploration of how to deal with people who have treated him badly with an after thought that maybe he has denied them the opportunity to accept him. By reflecting this phrase back to the client the therapist privileges self agency over determinism. By reflecting back the client's final phrase which relates to ownership or control of actions in preference to the previous phrase which relates to external control - which could also have been a possible intervention. In making this choice he is

reinforcing the client within the person-centred agenda of autonomy and individual control rather than focusing on the inter-personal nature of the client's story which constituted the bulk of the previous utterance. The message to the client is that he is in control of his life. The client replies with the brief acquiescent comment, 'right'(6.04) but does not appear to take on board the notion of his own responsibility or degree of choice. The therapist then continues with an interpretation relating to the client's resistance to expressing emotion (see below). It is almost as if there is a battle throughout the session between an interpersonal narrative (client) and an intrapsychic narrative (therapist).

This occurs again in the following example which is quoted in its entirety,

Example 2

20.41-21.44 C Yeah, and my friend said y'know one of these days, he says if you don't get it together, or something he says, not if you don't get it together, but y'know one of these days you're just gong to really lose it y'know, y'know what I mean? Its like I want to get rid of all that stuff that was done to me and not have to hear all that other stuff or to be able to deal with with it in a very constructive kind of a way y'know but still it grinds me because of all the other stuff that's happened to me and when I see other people doing it to other people it grinds me and makes me angry y'know and I would like to think that in those situations I began to kind of try to strike out like y'know protect somebody else or fight for somebody else or whatever and I'm not sure what I did for myself all those years when all that happened to me or whatever (.) and (.) if I could cry and have it [be all right]
21.46 R [Thats what I was thinking]. I was just thinking if you could only cry=

Here the client speaks at length and with emotion about his desire to deal constructively with his anger but the therapist reflects back only the last statement about the need to cry. This relates to a therapeutic discourse concerning emotion and catharsis but ignores many other possible areas that may have been relevant to the client and could have equally been reinforced if the agenda were open. For example, wanting to deal with the material from the past in a constructive way, the anger generated by observing the same things continuing to happen to other people, the feeling of needing to help these other people (which in fact might be a constructive way to deal with material from the past) and a questioning about how he dealt with the situation himself. In fact there is much here that could have been developed further. The ensuing interchange is around the

reasons why it is difficult to cry which again moves away from the client's interpersonal agenda and into the therapist's internal agenda based on emotional catharsis.

Example 3

In the final example the client's choice of anger as an appropriate topic for the session is reinforced by the therapist's reflective intervention which also adds credence to the topic of anger by emphasising the fact that he too has been giving it some thought. This results in the client continuing to talk about anger. Anger is mentioned four times in the next client utterance (1.11 – 1.46).

1.02 C 'when we talked earlier about the the anger I've been thinking a great deal about that =
1.07 R =I've thought a lot about what you had to say about that mm

The client does not reflect back the therapist's utterances or attempt to discipline his narrative in this way.

5.3.3. Congruence

Congruence is defined by Rogers in the following way, '...the feelings the therapist is experiencing are available to him, available to his awareness, and he is able to live these feelings, be them, and able to communicate them if appropriate.' (Rogers, 1961: 61).

The term 'locality' is used by Kogan (1998) to refer to the strategy by which the therapist signals that they are 'with the client' and seems to be synonymous with the concept of congruence as used in person-centred therapy. It is to do with the relationship between the two rather than the content of the utterances. It's function is to help the client to feel understood. In this session **the therapist** uses this strategy to ratify and validate the client's story.

Example 1

Using the technique of congruence the therapist tells the client that he is experiencing strong feelings but this may also be a projected wish for the client to experience strong feelings too and in a behaviourist context may be an example of modelling desired

behaviour.

8.05 (1)((looking down, intake of breath)) I get what you're saying and I also feel quite strongly ((eye contact)) that I want to say (2) its OK((nodding emphatically))with me if you're angry here

He then goes on to give the client permission to be angry in the therapy session. This is an interesting utterance on two levels. The client's previous account (7.02 –8.04) has actually been an instance of him 'being angry here' but is not explicitly acknowledged by the therapist despite this being a congruent intervention. Has he missed this or is he deliberately failing to address it? Secondly, in order to give permission one must be in a position of power. It is only the therapist's position of power that enables him to give the client permission to be angry. If the therapeutic relationship were symmetrical it should be possible for the client to give permission to the therapist but such an event is extremely rare and would be hard to imagine in this particular session. This is discussed further in section 6.

The client uses congruence frequently in the sense of communicating to the therapist his immediate feelings. For example,

I was thinking... (0.57)

When I think about that (3.08)

I'm not sure...(1.11, 1.15, 1.46)

I'm not sure how to respond to that..(8.51)

I don't really care to be..(2.50)

I certainly know what is happening now (4.05)

I really want to say that...(4.25)

In this way he is conforming to the therapeutic agenda by accessing his feelings and playing the role of the client. As he is behaving in role the client does not gain any power through the use of this strategy but he is contributing to the management of the relationship.

5.3.4. Interpretation

Although interpretation is an element in some therapeutic discourses it is not an intervention which is integral to the person-centred approach. As the notion of

‘following the client’ (Rogers, 1961) is paramount any attempt at interpretation would be seen as the therapist adopting an expert stance which is at odds with the model.

However I will demonstrate in the following examples that **the therapist** does in fact make some interventions which could be classed as interpretations in this session. These interventions share some common features such as beginning generally with markers such as ‘what I sense is going on’ or ‘I really do get that’ and the therapist’s strategy of talking as the client, ‘I really shouldn’t express my anger’ and all function to maintain the focus on themes linked to therapeutic discourse.

The first example is a therapist intervention following the client’s exploration of his feelings of needing to blame but also forgive.

Example 1

6.05 That’s what I sense is going on now that you feel (.) ‘there’s so many reasons why I really shouldn’t express my anger I’ll talk about all those reasons’

He is focusing the agenda back on anger and the client’s resistance to talking about anger. The client’s narrative on culture, racism and his feelings of victimisation are not selected as relevant to the therapeutic discourse but are seen as smoke screens erected by the client to avoid talking about his anger. This is followed by some paralinguistic signals and mitigating devices from the client (ten Have, 1989) suggesting that he is uncomfortable: laughter, avoiding gaze, dismissive tone, trivialising manner, euphemism, hesitation, increasing incidence of the ‘y’know’ tag. But he defers to Rogers’ expertise and conforms to the ‘anger agenda’ by admitting that it exists.

6.19 Yeah ((laughing)) for sure ((laughs, moves position)) (2) I don’t know really (1) y’know (1) if (2) ((claps hands on legs)) maybe I’ll just be angry one day ((laughing)) and maybe I’ll really feel better or whatever y’know and when I smile I’m aah (3) y’know ((lifts hand)) I’m smiling but (.) there’s a lot of (.) I’m sure you know that ((looks down)) (.) there’s a lot of anger there=

Example 2

The next example is especially interesting as it follows a long period of silence (14 seconds) in which the client appears to be grappling with his resistance to following

the therapist's formulation of his problem and has produced a therapeutic narrative of his own: the relationship between hurt and anger. The client is vulnerable here. In the previous utterance he has described his insight as a 'revelation' (9.42), a word which the therapist now reflects back as 'realisation' suggesting an understanding or comprehension of the situation rather than a revealing.

10.12 I really do get that that this realisation that ma:ybe what I'm most afraid of is the hurt that I might experience(2) em (1) makes you more ((hand gesture)) (1) cautious about whether you should or could really let go of the of the anger ((slow nodding, slow speech, slow hand gesture))

The delivery of this intervention is notably slower in all ways than previously perhaps in an attempt to add weight to its importance as a reinforcer of the therapeutic agenda. This agenda has not changed for the therapist throughout the session, it is still about recognising and demonstrating anger. The client's response shows that he is still resistant to this discourse as a 4 second silence occurs before he replies,

10.35 I really don't know I think that= ((Shrugs, shuffles, looks down))

And the reply indicates that he is not willing to take on board this interpretation and the non-verbal communication indicates a characteristic level of discomfort. In the ensuing episode the client continues to present his opposition to demonstrating his feelings.

The client does not present interpretations in any form as this is not within the role proscribed for him by the therapeutic discourse

5.3.5. *Challenge*

Although the person-centred approach tends to downplay the intervention of challenging, it still has a role to play in this model. The main overt challenge by **the therapist** that occurs in this session is when he dismisses the client's narrative as an avoidance tactic to deny his feelings and avoid the therapeutic agenda,

6.05 That's what I sense is going on (.) now that you feel (.) 'there's so many reasons why I really shouldn't eh express my anger I'll, (shaking head) I'll talk about all those reasons' (smiles)

The client uses humour to offset the potential rupture in the relationship caused by

this challenge and also gives in by admitting that he does feel angry.

6.19 Yeah (laughing) for sure (laughs, moves position) (2) I don't know really (1) y'know (.) if (2)(claps hands on legs) maybe I'll just be angry one day (laughing) and maybe I'll really feel better or whatever y'know and and When I smile I'm aah (3) y'know (lifts hand) I'm smiling but (.) there's a a lot of (.) I'm sure you know that (looks down) (.) there's a lot of anger there= ((Looks down, hand gesture – emphasis, laughs, looks down right))

However, the therapist is not prepared to leave it there and repeats his challenge a few seconds later,

6.53 Yeah mm and eh (2) so I hear you explaining and explaining (2) that eh 'its not my nature to be angry its just that I am angry right now'.

The challenge is still unsuccessful as the client embarks on a long episode of story telling narrative still avoiding the therapist's agenda (7.02 – 8.03).

It is always difficult for a **client** to challenge a therapist as this is not part of the proscribed role of client. There is just one instance in this session where the client asks a direct question of the therapist,

8.26 You really believe that?

It follows the episode where the therapist has persistently challenged the client to stop avoiding the expression of emotion and is immediately preceded by the therapist's repetition of his granting of permission for the client to express his anger. The utterance is accompanied by a vague smile and a quizzical look. On the surface it is a testing out of the therapist's genuineness.

Later the client challenges again but more indirectly, mitigating the utterance with humour

18.51 For sure (1) mm (1) ((laughing)) I have a suspicion that maybe you know ((reaching for water)) some things that I don't know ((laugh)).

In both example the therapist responds to the challenge with a blocking strategy, 'Damn right' (8.28) in the first case and, 'No (.) no I'm not holding out on you' (18.59) in the second. Neither allows for any development of the challenge.

5.3.6. Resistance

Rogers distinguishes between two types of resistance. The first is the client's resistance to the revealing of feelings which have previously been denied to awareness and the

second is the client's resistance to the therapist created by the therapist offering interpretations and value judgements. Rogers argues that person-centred therapy avoids the second type of resistance by creating a safe therapeutic environment within which there is nothing for the client to resist against and he can realise that thoughts and feelings projected onto the therapist are in fact his own (Kirshenbaum & Henderson, 1989).

In this session the therapeutic agenda is clearly related to the first type of resistance mentioned above but it is argued here that the client is in fact resisting this therapeutic agenda throughout the session.

The client offers resistance to the therapeutic agenda of expressing emotion a number of times within the session. The first examples are taken from the first section in the interview when the therapist's agenda focuses on the client's need to get in touch with his anger. The client resists this in a number of different ways. Initially he says that he doesn't want to be angry,

1.11 but I'm not sure ((laughs)) if I can do that y'know? ((looks down))

4.39 its not all that good to be angry

6.49 but its not my nature to be angry

Later the resistance changes to not knowing how to be angry

8.16((smiling)) But I don't (.) y'know its hard to know(looking away)) how [to be angry] y'know?

Then he moves onto not believing that the risk of being angry would be worth the return,

9.42 I'm not really sure that em(4) risking being angry (shaking head)

14.32 I don't know if there's any value in it

The focus of the therapeutic agenda moves from anger to hurt later in the session and the client also presents a resistance to the expression of hurt. This is a repetition of the previous theme,

22.25 but crying for myself I'm not sure that em (.) just not sure thats going to be constructive (1)
y'know (2) ((laugh))

The therapist deals with the client's resistance in a number of ways.

In the first example the client attempts to resist the anger agenda by distancing himself from the emotion by making a distinction between anger being a part of his personality and his current experience of the emotion - he resists ownership. It is interesting that the basic premise of Rogerian therapy is the relationship between the organismic (real) self and the introjected self and the client here is voluntarily making a similar distinction between his experience and his perception of himself.

Example 1

6.45 C =but its not my nature to be angry (5) its not my nature to be angry but I feel angry

R Yeah mm and eh (2) so I hear you explaining and explaining(2) that eh its not your nature to be angry its just that I am angry right now

Here the therapist reflects back the client's phrase but in such a way as to dismiss the point that the client makes as not worthy of exploration. The emphasis on the word 'explaining' and its repetition serve to devalue the client's words. Explaining is not part of the therapeutic process – rather it is an avoidance strategy seems to be the message. However the strategy does not seem to be very effective as it results in the client explaining (again) at length his desire to be 'angry in a productive way'.

7.38 I'd like to work with th:at and like to try to communicate without alienating (.) people or whatever

He goes on to reiterate the earlier themes of the way that others treat him- victimisation and racism and he focuses on the interpersonal issues around communication with others and his need to be heard. He is still not getting in touch with his anger as the therapist would like.

Example 2

In this episode the client presents his view forcefully, maintaining eye contact throughout and occasionally moving forward in his seat. He is talking about the way that he now feels less tolerant of people who send him messages about non-acceptance

and is clearly expressing anger here.

7.50 don't tell me about the way that I should do it or or give me all that non-verbal stuff about eh (1) saying that I'm OK but by non-verbally saying hey y'know you're really not OK and I don't want to hear that kind of stuff anymore

The therapist again does not connect with the content of the client's turn but reinforces the 'anger agenda' only this time it is done with more emphasis (using the word 'strongly'). He appears to interpret the client's response as indicative of a resistance to expressing emotion due to lack of permission to do so. Therefore he uses immediacy to offer this permission. However, the fact that he has the power to give permission reinforces the power differential in the relationship and his role as therapist expert. This seems to be an attempt to exert pressure on the client.

8.04 (1) I get what you're saying and I also feel quite strongly that I want to say (2) its OK with me if you're angry here

This results in a blocking of the client's flow - a breakdown of empathy - and an initial resistance, 'But I don't...' followed by, 'its hard to know how to be angry'(8.16) or perhaps an appeal for help -I don't know how to do what you are asking of me.

Rogers responds with support and denial of the challenge,

8.19 Sure, sure. I'm not saying you have to be

But restates his permission for the client to be angry but this time, on the surface, giving the choice of expressing anger or not back to the client.

8.21 I'm just saying its OK with me If you feel like being angry you can be angry

However this is not a true choice as the client has already demonstrated that he doesn't want to express anger and rather than move onto another topic (in the spirit of 'following the client') Rogers has continued with his 'anger agenda' reinforcing it by emphasising his power to give permission.

The client responds with a subdued,

8.26 You really believe that?

Followed by a long silence of 10 seconds accompanied by non-verbal signals such as shaking head, sigh, averting gaze which indicate how uncomfortable he feels.

5.3.7. *Talking as Client*

An interesting feature of **therapist** interventions in this session is the tendency for the therapist to speak as the client. There are six main examples of this throughout the text. By talking as the client the therapist may be trying to communicate an empathic understanding of the client's feelings but there is something infantilising about the strategy that goes beyond Rogers own definition of empathy. For Rogers empathy refers to an ability to see the client's thoughts and feelings as he sees them himself without any judgement or evaluation (Rogers 1961). The manner in which the therapist offers these reflections to the client does not convey that he is checking out his understanding of the client's world to see if he has understood accurately, but rather that he is taking over the world of the client and modelling the 'correct' responses for the client.

It is similar to the way in which adults often speak for young children when encouraging them to say what is required of them. Thus the therapist plays the role of parent to the client's role of child. To summarise the utterances above, the therapist puts the following words into the client's mouth,

(.) 'there's so many reasons why I really shouldn't eh express my anger I'll, ((shaking head)) I'll talk about all those reasons' ((smiles)) (6.05)

'its not my nature to be angry its just that I am angry right now'((hesitation, looks down)) (6.51)

'that ma:ybe what I'm most afraid of is the hurt that I might experience'(2) (10.12)

'Suppose I really expose to somebody the fact that I'm (1) deeply, deeply hurt, that in a sense would be comparable to (.) having to be dependent on someone when you can't walk or something like that?' ((Hand gestures)) (11.58)

'I really was defeated (1) at times' (.) (14.08)

'=I'm hurting' (15.49)

These utterances all conform to the therapist's agenda of fear of expressing emotion. By reflecting these particular phrases back to the client the therapist is reinforcing his agenda again. However this strategy of speaking as the client is also a means of colonising the client's individual sense of self. The therapist has now subsumed the

client into himself by speaking for him.

There are two different effects of this. The first is the use of humour by the client as a mitigating device, for example,

6.19 Yeah (laughing) for sure (laughs, moves position) (2) I don't know really (1) y'know (.) if (2)(claps hands on legs) maybe I'll just be angry one day (laughing) and maybe I'll really feel better or whatever y'know and and When I smile I'm aah (3) y'know (lifts hand) I'm smiling but (.) there's a a lot of (.) I'm sure you know that (looks down) (.) there's a lot of anger there= ((Looks down, hand gesture – emphasis, laughs, looks down right R – touches head, nods))

The client is uncomfortable as can be seen by the body language and uses humour in an attempt to lighten the atmosphere but ends the utterance by conforming to the therapist's agenda and admitting that he is angry. The phrase, 'I'm sure you know' indicates a belief in the expert role of the therapist and the recognition of the futility of disagreeing with the therapeutic agenda.

The second type of response used by the client is to offer further resistance through an initial period of silence followed by a denial of the therapeutic discourse. For example, four seconds of silence follow the therapist's utterance and precede this response by the client.

10.35C I really don't know I think that= ((Shrugs, shuffles, looks down))

In a further example, the therapist's intervention is followed by 8 seconds of silence after which the client presents the following resistance to the therapist's agenda by questioning the value of the strategy of getting in touch with emotions.

14.27 C y'know (.) being,(3) having it being alright to be defeated and (.) be beaten and (.) I don't know if there's any value in (2)

Therefore, the empathic intervention does not lead to a therapeutic step forward but rather a fracture in the therapeutic relationship.

The client does not speak as the therapist at any point in the session.

5.3.8 *Back-channel communication*

This session is characterised in a typically Rogerian manner by a paucity of therapist intervention and a lot of encouraging verbalisations such as 'mm, aha'. These are

referred to as back-channel communication (Kogan, 1998) and serve the function of moulding the client talk. They are reinforcers. These interventions can be seen to follow client utterances which engage with the therapeutic agenda of expressing emotion.

Example 1

3.00 C For sure (3) I think that I could probably trust that (.) a lot better than than trusting whats happening or what has [happened],

R [mm mm]

The client is referring to trusting his own gut feelings rather than trying to rationalise his experiences. As this is part of the therapeutic agenda it is reinforced by the therapist.

In the next two examples the therapist uses back-channel communication to reinforce the client's engagement with the topic of anger. In both cases the non-verbal communication signals the client's discomfort with this topic.

Example 2

6.19 C Yeah (laughing) for sure (laughs, moves position) (2) I don't know really (1) y'know (.) if (2)(claps hands on legs) maybe I'll just be angry one day (laughing) and maybe I'll really feel better or whatever y'know and and When I smile I'm aah (3) y'know (lifts hand) I'm smiling but (.) there's a a lot of (.) I'm sure you know that (looks down) (.) theres a lot of anger there=

R mm

Example 3

9.27 C (2) Really (laugh) em((moving position)) (6) I keep getting these blo:cks y'know these y'know (.) when I come to something like that y'know because (.) y'know to me thats a revelation and I'm not really sure that em (4) risking being angry ((shaking head)) I guess or something like that y'know ((smiling))(2) losing control maybe

R ahha

The client also uses a lot of back-channel communication in the session. However this takes the form generally of agreement phrases such as 'for sure' which follow a therapists intervention and serve the function of signalling compliance to the therapeutic agenda.

Example 1

1.48 R Your mind says you're to, oh, cool it don't don't get (1.5) into eh strong emotion=

1.54 C ((nodding)) = for sure, it almost...

and later,

2.21 R But some other part of you is saying 'yeah but there's some anger there'.

2.24 C for sure, for sure

However, although signalling compliance the client often continues with his avoidance of the therapeutic agenda. For example in the challenging sequence (6.05-8.28) the client begins his speech (7.02) with ‘for sure’ but then continues with an exploration of his need to be angry in a productive way.

5.3.9 Para-linguistic signals

In the analysis of the therapist and client stories paralinguistic signals have been mentioned as part and parcel of the narrative style used by the protagonists. However, these signals when observed together form a system of their own and serve functions within the relationship itself. The use of humour as a mitigating device is a feature of both therapist and client utterances and is used here as an illustration of para-linguistic signals in this text.

Example 1

The challenge itself is delivered by the therapist with a smile to mitigate the challenge,

6.05 That's what I sense is going on now that you feel (.) ‘there’s so many reasons why I really shouldn’t express my anger I’ll talk about all those reasons’ ((smiling))

Humour is also used by the client to resist the therapist’s challenge to express his anger,

6.19 Yeah (laughing) for sure (laughs, moves position) (2) I don’t know really (1) y’know (.) if
 (2)(claps hands on legs) maybe I’ll just be angry one day (laughing) and maybe I’ll really feel
 better or whatever y’know

It has the effect of allowing the client to avoid the therapeutic discourse but in a non-confrontative manner.

It is used again in response to the therapist’s comment that having to expose his hurt is a big risk to the client. Rather than explore this issue more deeply the client makes a joke,

11.51 Yeah it is ((laughing)) It seems to be getting bigger and bigger as we talk ((looks down))

The therapist continues with the theme but the client again resists,

12.14 ((moves head, closes eyes, smiles)) Right (8) Yeah, I’d like to just to say that's like my condition ((laughing)) that's one way out of it.((laughing, hand to face)).

However he now begins to conform to the agenda of avoidance by acknowledging

that he would like to make an excuse and avoid having to confront his hurt. The phrase ‘that’s one way out of it’ demonstrates the client’s feeling of being trapped by the therapeutic discourse.

Example 2

Humour is also used as a self-deprecatory strategy in order to distance the client from the pain of his narrative. The client is talking here about being a victim and before and after the utterance quoted he speaks seriously and quietly

14.43 but y’know that I’m really finding out I’ve got a lot of hangups ((laughing)) in terms of in that line

The client looks upwards and avoids eye contact as he speaks.

This quote comes from an episode where the client is talking about the difficulty he has in crying,

23.22 (.) I wonder how many people have seen me cry ((head back, laughter in voice))() two or three in the whole world [laugh]

Example 3

Humour is again used by the client following a long silence (18 seconds). This time it is linked with another mitigating device that of drinking some water.

16.20 C I don’t know (2) how to get that up at all ((laughing, drinking water)) (6)

Every time I get close to that I take a drink of water

R {Yeah ha ha ha ha} ((nodding))

C {((laughs, shifts forward & back in seat))} (3) Ha I don’t know if that (.) acts to keep it down [or not]

As the therapist joins in with the laughter the tension created by the silence is relieved.

The sharing of the laughter signals the achievement of a shared understanding and ‘togetherness’ which is important for the maintenance of the relationship

5.3.10 Silence

In person-centred therapy silence is seen as a space in which the client is allowed time to get in touch with his feelings and experience these in the present. There are a couple of episodes in this session where long silences occur and they are accompanied by non-verbal signals of distress. It is argued here that silence is used as a strategy by the

therapist to challenge and exert power over the client.

Example 1

The first period of silence occurs approximately eight minutes into the session and lasts for 18 seconds. It follows a lengthy episode where therapist and client are battling for control of the agenda. Despite the client's attempts to resist the challenge,

8.16 C ((smiling)) But I don't () y'know its hard to know(looking away)) how [to be angry] y'know?
Rogers continues to reassert his position and his dominant role by giving the client permission,

8.19 R I'm not saying you [have to be]

C [For sure]

8.21 R I'm just saying its OK with me (2) if you feel like being angry you can be angry

The client offers an ambiguous question accompanied by a quizzical smile which comes across more as a sign of resignation. The strength of Rogers' response is signally by the use of the word 'damn' -

8.26 C You really believe that?

R Damn right

During the period of silence which ensues the client looks down, shakes his head, shrugs, sighs. He is under pressure and very uncomfortable. The therapist stares unflinchingly at the client throughout. The silence is eventually broken by the client,

8.51 ((looking down)) I'm not sure how to respond to that at all (2) y'know (.) because a part of that anger is all the hurt and maybe if I maybe ((looking up)) whats happening is that if I become angry and I re:ally let it hang out (.) that I really will see how hurt I [am] (1) a:nd em

Again eye contact is avoided and the utterance ends with a mitigating smile and eye contact. The client conforms to the therapeutic agenda by offering an alternative emotional topic – hurt.

Example 2

A further period of silence of similar length occurs approximately eight minutes later.

This is preceded by a discussion around the topic of mutuality and the client's agenda of not wanting to be beaten but also wanting something in return .

15.20 and I'm going to start I think expecting that (1) without being cold or anything like that but I have to (.) y'know start getting something back in return

The therapist continues to assert the therapeutic agenda of engaging in emotion by reflecting back the client's sense of fear about exposing his hurt to others rather than developing the theme of mutuality,

15.49 R Something really awful about showing, letting anyone know that 'I'm hurt,=

C yeah

R 'I'm hurting

The client responds by resisting this theme and providing almost a list of the issues which have been client themes throughout the session,

15.56 Sure (.) ((looking down)) sure its (1) y'know it has something to do with being a man, it has something to do with (.) with the race ((eye contact)) thing, y'know (.) It has something to do with the relationship (1) maybe the failure of a relationship a (3) a lot of things y'know a father not being in the home with his children (5) I really feel like being a victim

As before the client then remains silent for 18 seconds and sits very still, looking down until he reaches for a glass of water and breaks the silence with the following,

16.20 C I don't know (2) how to get that up at all ((laughing, drinking water)) (6) Every time I get close to that I take a drink of water

R {Yeah ha ha ha ha} ((nodding))

C {((laughs, shifts forward & back in seat))} (3) Ha I don't know if that (.) acts to keep it down [or not]

The mitigating devices of humour and taking a drink of water are both used to release the tension. An appeasement gesture of glancing up at the therapist before taking a drink signals that the client resigns from the battle.

5.4 Section 4: Parallel Process

‘We find that the crucial actions in establishing coherence of sequencing in conversation are not such speech acts as requests and assertions, but rather challenges, defences and retreats which have to do with the status of the participants, their rights and obligations and their changing relationships in terms of social organisation’ (Labov & Fanshell 1977:.58).

This final section of the analysis of this text proposes that the text offers another level of meaning which is not unveiled in the previous sections of the analysis. This reading suggests that a parallel process is operating between the client’s narrative of his lived experiences and his actual experiences of the therapeutic encounter. His anger toward the society that he lives in and the treatment that he has suffered is directed at the therapist himself in what might be termed projection in psychoanalytic terms. He sees the therapist as a representative of that culture and therefore an appropriate target for his frustrations. It is not suggested here that the client is conscious of this process but rather is demonstrating what de Certeau (1984) refers to as ‘double consciousness’ (p. 155) or the construction of a second symbolic space in which to maintain the integrity of the self whilst under threat from another.

5.4.1 Themes

The analysis reveals five themes that suggest that there may be two different processes operating in this session: time, trap, trust, representative and failure of relationship.

Within each of these themes there is a dual meaning for the client. Although generally the client is presenting an external narrative, there is also a way in which his utterance could be understood as a comment on the therapeutic relationship itself.

5.4.1.1 Time

There are a number of markers which indicate that the client is aware of different time frames and the parallels between then and now,

1.55 whatever is ha:ppening in my environment or whatever happened in my environment

3.04 trusting whats happening or what has happened

4.05 I certainly know what is happening now and what has happened

7.12 Its like n:ow when I when I 1) I respond (1) to people

9.01 maybe ((looking up)) whats happening is

As the session progresses a subversive client narrative can be read which mirrors the client's real life experience.

5.4.1.2 Trap

The feeling of being trapped and having limited options although on the surface referring to real life experiences may also refer to the current therapeutic situation,

1.55 whatever happened in my environment is pulling me into, again (1.5) aah that kind of a trap ((eye contact)) that kind of a system that (.) I don't particularly ca:re (2) y'know ((shaking head)) if you know what I mean

2.30 you only have about two ((eye contact)) options

5.4.1.3 Trust

The client indicates his wariness about the process itself and it's strangeness,

3.00 I could probably trust that (.) a lot better than than trusting whats happening

3.26 but a lot of things have been strange ((emphatic nodding))

and later his fear of trusting the therapeutic relationship,

11.40 to show somebody that I'm that I'm hurt? And how can I trust that to somebody y'know?

And finally his resignation,

26.11 I don't trust that its been worth it you see

5.4.1.4 Representative

The idea that the therapist is representing the society in general is indicated a number of times in the text. Firstly where the client states his desire to find an individual to blame and achieve justice in this way,

4.59 mm for sure, for sure (.) for sure (1.5) and I kee.. and theres nobody that I can put my finger on y'know that person that started the whole thing, that process y'know, because that would probably be a lot better for me y'know then I probably ((looking up))

and perhaps most clearly,

20.24 y'know I really saw him, the society, the culture right in him y'know. And I really wanted to just kinda deck him

5.4.1.5 Failure of relationship

The client's desire for reciprocity and mutuality in relationship is part of his narrative theme around the notion of justice but again this may be reflected within the

therapeutic relationship itself. He feels he is trying his best but it isn't enough,

13.19 I did the hel best I could and it wasn't good enough (.)

and the process is only working in one direction,

15.26 but I have to (.) y'know start getting something back in return

29.14 I wasn't getting anything, any nourishment y'know?

When the client talks about relationship in his story he may also be referring to the current therapeutic relationship and his sense that this has been a failure too.

16.02 It has something to do with the relationship (1) maybe the failure of a relationship

15.32 I don't want to have to get in the situation like I'm in now y'know where I'm afraid to show anybody that I'm hurt(.) y'know scared to death, terrified.

5.4.2 *Episodes*

Two episodes from the text will now be presented in detail to illustrate the alternative reading of his material.

5.4.2.1 *Episode 1: Messages I'm getting* (6.53 –8.51)

This episode begins with the therapist challenging the client by suggesting that he is avoiding engagement with the therapeutic agenda of getting in touch with his anger.

6.52 Yeah ((touching head)) mm and eh ((looking down))(2) ((eye contact)) so I hear you explaining and
6.53 explaining (2) that eh ((looking down)) 'its not my nature to be angry its just that I am angry right now'

The turn now shifts to the client who must, within the rules of the discourse, respond to the challenge of the previous utterance. He starts with the mitigating device of agreement accompanied by laughter, averted gaze and body shifting but then resists the challenge by stating that he does not know how to be angry in a productive way (7.06).

He then, on the surface, reverts to his own agenda of describing the experiences of non-acceptance in his life that have made him feel angry. However there are markers here which alert us to the idea that this speech is directed at the therapist himself and the client's frustration with the therapeutic process. For example:

7.11 Its like no:w ((looks right))

7.19 whether its i:n ah professional situation or (.) whatever ((looks right))(2)

7.31 there are certain kinds of messages that I'm getting ((raise eyebrows, quizzical look)) (.) y'know

7.40 I'd like to work with th:at and like to try to communicate without alienating (.) people

Gaze, facial expression and bodily posture are also indications of the sub-text of this episode. The client delivers this speech in a measured and deliberate tone. When he averts his gaze it is momentary and he looks to the right (7.10, 7.24) which tends to be a space for thinking rather than the avoidance of eye contact associated with the look to the left (7.04) more often related to discomfort. The client is not uncomfortable here . As the speech proceeds he becomes increasingly emphatic as indicated by the long period of eye contact(18 seconds - 7.36 – 7.54), the use of stronger language, (7.49) and the threatening body posture of moving forward (7.45). His direct use of commands towards the end – ‘don’t tell me’ and ‘I don’t want to hear’ are delivered with force. This is a warning.

C (7.02) For sure ((laugh, looks down left)) for sure ((shrug)) (.) and I try ((shaking head)) to be angry in (7.06) a productive way I don't know how ((eye contact)) you be angry in a productive way y'know?
(7.10) in terms of (1). Its like no:w ((looks right)) when I when I (1) I respond ((eye contact)) (1) to (7.14) people y'know it, it when you encounter people y'know whether its I:n the street ah whether (7.18) its I:n ah professional situation or (.) whatever ((looks right))(2). Y'know if people ((eye contact)) send out certain messages (eye contact)(1) a:nd ((looks right)) no no ((eye contact)) (7.29) matter what they're saying or whatever there are certain kinds of messages that I'm getting (7.31) ((raise eyebrows, quizzical look)) (.) y'know, They're saying that hey y'know ((shift gaze)) that (7.34) that isn't for me kind of thing (.) y'know. (1) and as befo:re y'know I'd like to work with th:at (7.40) and like to try to communicate without alienating (.) people or whatever but now y'know I'm (7.45) ending up saying ((shrug)) y'know like hey thats a bunch of crap. (1) ((shifts forward and back in seat)) y'know don't don't tell me ((emphatic)) about the way that I should do it or or give me (7.53) all that non-verbal stuff ((looks right)) about eh (1) em saying ((eye contact)) that I'm OK but (7.58) by non-verbally saying hey (shaking head) y'know you're really not OK y'know and I don't (8.02) want to hear that kind of stuff anymore

The client ends with the counter challenge to the therapist (8.02). He is staring at the therapist as he finishes speaking but the therapist himself is avoiding eye contact as he begins his turn. This is a rare example of the client's dominance in this session.

However it is fleeting. The therapist resists the challenge by making another narrative transformational shift. He acknowledges verbally that he has heard and understood (8.04) what the client has said but reasserts the therapeutic agenda of anger expression rather than engage with the client's account .

8.05 (1)((looking down, intake of breath)) I get what you're saying and I also feel quite strongly ((eye contact)) that I want to say (2) its OK((nodding emphatically))with me if you're angry here

The therapist hands the turn back to the client who does not respond for 5 seconds (811–816). He breaks off eye contact, looks down and gives a smile of disbelief. Again he has not been heard.

8.11 (5) ((eye contact, blinks, looks down, smiles))

At this stage the client makes one final attempt to resist the therapeutic agenda by saying that he really doesn't know how to fulfil this requirement. Previously the client has said that he doesn't want to be angry (1.10) and that its not good to be angry (4.25), now he is saying that he dosen't know how to be angry. The utterance is delivered through a smile as though the client is not taking himself seriously any more. The averted gaze to the left also indicates a withdrawal from the interaction.

C 8.16 But I don't () y'know its hard to know ((looking away, left)) how [to be angry] y'know?
R 8.17 [sure, sure]

The therapist overlaps his turn and speaks over the client at line 8.17. The client then does the same thing in line 8.20 when he overlaps his turn with the therapist's utterance. This sequence demonstrates a break down in the conversational structure, a struggle is taking place. The therapist retreats behind a clarifying intervention where he asserts that he is not demanding that the client be angry but just giving him permission to be so if he chooses. This is a realignment with the non-directive approach of the person-centred model. It is also a denial that any power has been exerted over the client even if he may feel under pressure.

R 8.19 I'm not saying you [have to be]

C 8.20 [For sure]

R I'm just saying its OK with me (2) if you feel like being angry you can be angry

The therapist wins the struggle and restates his permission for the client to be angry.

The word 'feel' is used again.

The client's final response in this episode is an ambiguous question, accompanied by a quizzical smile – you don't really believe that do you?

8.26 (1) You really believe that?

The client's disbelief is complete and the therapist's persistence has paid off.

R 8.28 Damn right

There follows one of the longest silences of the session – 18 seconds.

5.4.2.2 Episode 2: *A bunch of intellectual garbage about feelings* (20.02 – 21.46)

Later in the session there is a sequence where the client repeats this theme in an almost identical way. On the surface the client is again explaining how he feels angry when encountering people who represent the society that he lives in and are in some way responsible for what happened to him. However if taken as an example of a deeper more direct message to the therapist we can see how the client is challenging Rogers and the therapy as yet another example of victimisation. The description of the individual in the narrative is a perfect fit for the therapist himself. The client is talking about his powerlessness and lack of control but the word control is accompanied by a laugh and a shift in body posture indicating the need to mitigate this risky move.

20.02 I don't know if I have any control ((smiling)) over that ((shifts back and forth in seat)).

In the previous section he refers to 'professional situation' and here he uses the term 'a very intelligent sort' to indicate that this utterance is about the 'here & now' as much as it is about the past,

20.13 y'know a very intelligent sort that was (.) talking a bunch of (.) intellectual garbage about (.) feelings and and things like that.

This can clearly be seen as a comment on the client's feelings about the therapist himself. The client paradoxically smiles gently to himself as he makes this statement. Is this leakage? He explains that this type of person makes him feel so angry that he would resort to physical violence even though this is not a natural response for him

20.31 And I really wanted to just kinda deck him and thats something thats not eh my nature whatever

The reason for this anger is given in a sub-clause explaining that for the client this type of person is a personification of the society which he believes has treated him so badly,

20.24 (.) y'know I really saw him, the society, the culture right in him y'know.

The theme of anger is an accurate and relevant one for this therapy session but the client's anger is about his role in society and the discrimination that he has suffered. Despite the therapist's adherence to the person-centred approach, which is underpinned by respect for the person, the client is picking up the same messages from this therapy session that he has been subjected to all his life. People want to talk about feelings but only on their own terms. They do not want to hear that they, or their generation or gender or race or social class or educational status make them the cause of the suffering of others. They do not want to take responsibility. Within the session there is no engagement at this level, there is no mutuality or reciprocity. Rogers is not willing to meet the client on equal terms. The client presents himself openly as an individual whose sense of self is a product of his gender, age, race, class and education but Rogers does not reciprocate by presenting himself in the same way – a middle class, middle aged, professional, white man. He remains distant and aloof and safe in his role as therapist. There is no contact between the two as individuals representing the powerful and powerless classes of their society in that historical period and no recognition on Rogers' part that this is a critical part of the relationship between the two men and one which is of great significant to the therapeutic process.

Previously in the session the client has voiced his frustration at being unable to pin his anger on any one individual. If he could he would be able to express his anger by 'doing that person in'. The episode above is an echo of this theme although now there is a more specific description of what this representative of society would be like and the reality is that Rogers fits the description.

5.4.3.3 Episode 3: Being a victim (12.56 – 15.52)

This episode begins with a one minute monologue from the client (12.56 – 13.56) which can be interpreted on two levels.

On the surface the client is attempting to explore his emotions and thereby conform

to the demands of the therapeutic discourse. He moves away from the contentious theme of anger and instead introduces a new emotion – love but also continues the theme of hurt introduced in the previous episode. However, the narrative soon reverts back to the client's theme of being a victim through his tracing of his feelings of hurt back to his experiences of victimisation. He reasserts his own agenda here and this leads toward the end of the monologue to the introduction of a new theme – reciprocity. The client ends this episode by firmly asserting that he is going to demand something in return.

On a deeper level this episode can be read as a more direct communication with the therapist about the therapeutic process. The therapeutic process is paralleling his experiences of life. He is feeling inadequate and pressured by the demands of the process,

13.19 I did the hel best I could and it wasn't good enough (.) y'know a:nd (1) y'know demand on top of demand and everything like that y'know

He has tried to engage with it and has an aim of his own,

13.08 and em y'know and that's ((emphasises with hand gesture)) about the only thing I really like to get out (.) to really get out y'know and maybe saying y'know like I love somebody?(1)

This second example is accompanied by the familiar markers which indicate both the client's need to be heard and the level of risk involved in the utterance - the lapse into the vernacular, the increase in hesitations and the avoidance of eye contact (c.f. 736). The emphasis on the word 'like' indicates that he would really like to engage with therapy , he is not being difficult but the problem is that he is not being heard,

13.39 and I said this ((shaking head)) the other day ((hands to face, looking down)) when I was talking to you

The client then restates his victim agenda. He is the victim in this relationship.

Interestingly the client here uses the phrase, 'on another level'(13.54) as though to indicate his awareness of the different levels operating within this process. The client's

emotions are very near the surface in this section, there is a tremor in his voice, he wrings his hands and he maintains eye contact. The client presents his themes to the therapist again; victim role, pride and conflict .

Apart from an encouragement at line 13.57 the therapist remains silent throughout the client's turn until his intervention at line 14.08 when the client relinquishes the floor at the end of the emotional episode. His intervention at his point is a reflection of the client's sense of being defeated. Rogers again uses his device of speaking as the client,

You don't want to say 'I really was defeated (1) at times' and yet ((shaking head)) that's the truth (14.08).

Although the intervention on the surface appears to be staying very close to the sense of the client's story it is in fact a focusing of the whole account into the one theme of the client's acceptance of his sense of defeat. This theme is congruent with the person-centred approach and its aim of striving toward authenticity. The client must accept his feelings of defeat because they represent 'the truth', his real, authentic self.

In the next frame the client is indeed the picture of defeat. He initially responds by agreeing with Rogers in a very small voice,

14.16 mm (1) it is

but then he looks down, sighs, licks his lips and remains silent for 8 seconds .

The defeat here is his failed attempt to be heard again. The challenge which follows is a little more direct,

14.32 I don't know if there's any value in (2) y'know

The surface and deep processes merge at this point in the session. The client is talking about the therapy although he specifically resists the therapeutic aim of accepting his feelings of defeat. However the challenge is short lived as the client first uses the mitigating devices of humour and averted gaze,

14.43 ((looking left)) I'm really finding out I've got a lot of hangups ((laughing)) in terms of in that

line

to make light of the situation and also to concede that the problem is located in him.

Then the narrative shifts once again as the new theme of reciprocity is introduced,

15.06 like I'm a I'm a ki.. y'know I'm a kid ((shrugs shoulders)) and in a way I like to be loved too I like to be eh (1) some reciprocity.

The client is both referring to his desire for reciprocal relationships in his life but he is also referring to the clear lack of reciprocity in the therapeutic relationship. He then restates his desire as a demand or perhaps a challenge to Rogers,

15.20 but I have to (.) y'know start getting something back in return

The therapist responds with a true reflection, reinforcing the theme of mutuality but only acknowledging the surface level by repeating the word 'love'. He is engaging with the client's story but ignoring (or not hearing) the client's direct communication about their relationship.

15.31 you want love to be mutual?

The client then responds to this avoidance on Rogers' part by using a much more direct statement ,

15.35 and ((looks left, shakes head))I don't want to have to get in the situation like I'm in now ((eye contact)) y'know where (.) I'm afraid to to show anybody that I'm I'm hurt (.) y'know scared to death, terrified ((looking away))

Again at the surface level this is a comment about the client's feelings about his current life situation but it is also a very direct comment to the therapist who has spent the last 15 minutes not hearing the client's message. As in line 4.07 (but I certainly know what is happening now) the client uses the word 'now' to signal the change in level of process.

The client is subdued and speaks quietly he is defeated and hurt and is unable to trust himself to this therapy.

Again the therapist responds in keeping with the therapeutic model by reflecting back the emotional content of the client's utterance. But in doing so again diminishes the

client by speaking for him. In the light of the preceding section on the client's desire for reciprocity in a relationship this is particularly insensitive. Not only is Rogers not being reciprocal he is in fact meshing with the client and refusing to demonstrate an identity at all.

15.49 Something really awful about showing,(.) letting anyone know that (.) 'I'm hurt,=

The agenda has shifted again – away from the client's new narrative about reciprocity and mutuality and back to the therapist's discourse on getting in touch with emotion.

The client's final turn in this episode is a repetition of his topic agenda. This time it is presented as a list. He is almost spelling out for Rogers what the issues are that he would like to work on – gender, race, relationship, fatherhood, failure, absence from the home, and finally being a victim. These have all been presented elsewhere in the session but not taken up by the therapist. Later in the session (19.18)Rogers reflects this list back to the client indicating that he has accurately heard it. However at this point in the therapy it is not acknowledged.

15.56 ((looks down,left)) y'know it has something to do with being a man, it has something to do with (1) with the race ((eye contact)) thing, (.) y'know (.) It has something to do with the relationship (.)((looks away)) maybe the failure of a relationship a (3) a lot of things y'know a father not being in the home with his children (5) I really ((eye contact)) feel like being a victim ((maintains eye contact for 4 secs then looks away)).

There then follows an 18 second silence.

6.0 Discussion

6.1 Aims

The aim of the discussion is first to critically appraise the methodology and results of the study and to place them in context with regard to the existing research literature, and secondly, to consider the implications of these findings for practising counselling psychologists.

6.2 Interpretation of results

The session was analysed in terms of the therapist and client's narratives, the strategies used to manage the encounter and the hypothesised concept of the parallel process within the client's narrative. A summary of these analyses and their interpretations are presented below.

6.2.1 *Comparison of client and therapist narratives*

In considering the main themes present in the narratives of each participant in this encounter it becomes apparent that there is a major difference between those of the client and those of the therapist. In line with the notion of uni-vocality (Bakhtin, 1981) the therapist presents a coherent voice resting firmly within a therapeutic discourse. The therapeutic discourse within the person-centred tradition includes:

- Trouble defining: out of touch with real self, the problem is intra-psychic
- Therapeutic aims: get in touch with real self through emotion, empower the client
- Therapeutic relationship: should be equal and provide a medium for growth
- Client role: should be in the lead, on a journey toward self-actualisation.

Comparing these with Labov & Fanshell's (1977) four general therapeutic propositions⁵ there seems to be much in common. The fourth major theme of therapy

⁵Role partners should co-operate to solve mutual problems

One should express one's needs and emotions to relevant others

The therapist should not tell the client what to do

The 'patient' should gain insight into his own emotions (be in touch with his feelings)

they identified was that the patient should gain insight into his own emotions. For the therapist in this session the single theme identified in the narrative is that the client should get in touch with his emotions.

This theme is expressed in a number of ways throughout the session. It is established right from the beginning of the session as the therapeutic agenda. Although the client presents many different themes in his own narrative none of these are reflected back by the therapist and no opportunity is provided for the therapeutic agenda to change.

Rather, these alternative themes presented by the client are interpreted as resistance to the therapeutic agenda of getting in touch with emotion and equally, any mention of emotion by the client is reinforced by a reflection of the phrase used by the client. Many therapist utterances empathically relate to the difficulty that the client is having in expressing his emotion and serve to define the client's problem as his inability to access his anger because this will lead to his realisation that he has been very hurt. It is therefore understandable that he would like to avoid this hurt but in order to meet the goals of the therapy session he must be encouraged to do so and it is the therapist's role to resist the client's resistance. The therapist aims to create a therapeutic environment which may allow the client to access these 'deep' emotions and therefore increase his self awareness. As the session proceeds the theme remains strong but develops gradually from a focus on 'anger' to one on 'hurt' about halfway through the session and then again toward the end of the session another shift to the expression of sorrow through crying.

In contrast, the client's narrative includes four major themes:

- Anger and hurt about what has happened
- Mixed messages
- Need to be constructive
- Need to get something back; reciprocity, mutuality, value.

In the first he complies with the therapeutic agenda (and therapist narrative theme) in talking about anger and hurt. The themes of anger and hurt are consistent between the therapist and client agendas. The client's story contains a lot of emotion and he talks about these emotions in a discursive manner. However, his desire is not to feel the emotion more intensely but to understand it, the circumstances that have created it and the most constructive way in which to deal with it. The client does not deny his emotions at any point in the session but does express concern over the value of getting in touch with them. His preference is to find some meaning in the pain and some constructive use for the suffering. He tries on a number of occasions to explore the causes of his suffering which seem more related to the social and political context of the time than internal alienation from his true self but these themes are resisted by the therapist.

The second theme in the client's narrative is his experience of receiving mixed messages from people, of not being accepted. He is referring to the way that people have behaved in a 'two-faced' way with him. In not revealing their true feelings but pretending that they accept him but not really doing so. The fact that the client ends the session on this theme signals its importance for him. It has not been the focus of this therapy session but he is still trying to have that message heard. The episodes dealing with this theme in the transcript are characterised by a serious and assertive mode of delivery and this theme is the topic of the few long monologues that the client offers in the session. This message is important to the client.

In listening to the client's story one is struck by the strong moral thread running through this young man. Despite all the problems in his life the thing which is important to him is to see a value in his life. This existential theme of finding meaning is easily explained

through the client's circumstances⁶ but there is more to it than that. He not only wants to find meaning he also wants to find a way to forgive those who have hurt him, to work with trying to change attitudes of others and generally for something good to come from the bad. These thoughts are rooted in a strong commitment to a social and political agenda. The client makes sense of his life in a relational way. It is how he relates to others that is his most pressing concern. His narrative is full of stories about relationships, ranging from the abstract (his cultural persecutors) to the specific (his father-in-law, his wife) and his aim is to learn how to trust people again so that he can enjoy reciprocity in relationships. This is in fact the client's final theme. In many ways it echoes the previous theme of mixed messages as it relates to the notion of equality – of receiving as well as giving. The client draws on the moral discourse of justice in expecting life to be fair. If one works hard there should be a reward, if one gives out to other people one should receive something back in return. He feels that now is the time to make sure that he reaps some benefit from his hard work and sacrifice.

6.2.1.1 How do therapist and client present themselves in this session?

As a major theme of person-centred therapy is the concept of self and Rogers holds an essentialist notion of self, seeing it as something that exists and has influence over the individual it is interesting to consider the voice or voices of the self that can be heard in this interaction for both the therapist and the client.

Just as the therapist's narrative contained one single theme, it also contains a single image of the self. It is the 'therapist self' or the role of the therapist. There is little in the therapist's story that reveals a more personal self or allows a more rounded impression to be formed of the therapist.

Fairclough, (1992) uses the term 'ethos' to refer to the way in which an individual's social identity and subjectivity are signalled within discourse. In this sense the

⁶ The client is currently in remission from leukaemia.

therapist is using a therapeutic ethos to signal that he is in the role of therapist and this is his identity in the current situation. As the therapeutic derives from a more general medical and scientific ethos the presentation of self lies firmly in the expert role.

However the therapeutic ethos also conforms to a trouble-telling ethos (Jefferson & Lee, 1981) which positions the therapist as the sympathetic listener or even caring friend. From the analysis it is clear that the therapist is presenting himself as a willing listener committed to trying to understand the client's problems. This is signalled by both the direct declarations that he is trying to understand the client and his constant checking that he has accurately understood part of the client's narrative. It is also signalled by the quiet and steady tone of voice used by the therapist and his lack of interventions compared to those initiated by the client. The focus of the session is the client's story, the therapist does not respond to the client with a story of his own, or a story relating to another acquaintance as might be the case in another type of ethos.

However, the role of the expert is part of the therapeutic ethos and is signalled through the interpretations of the client's situation which are made by the therapist and the way in which he controls the therapeutic agenda.

In contrast the client reveals much of himself. This is in part reactionary. The client is positioned in the client role within the therapeutic ethos adopted by the therapist. While the therapist listens the client must talk; while the therapist is the 'doctor' the client must be the 'patient'; while the therapist is the expert the client must be the novice. The client allows himself to be positioned in this way but it is his reflective voice which comes across most strongly within the session. He reflects on his current situation, his past and his 'hoped for' future in a thoughtful manner. Within this he reveals his struggle with his own sense of self. His reference to different parts of himself and the use of metaphor revealing an awareness of different levels within himself are signals relating to the sense of a fragmented or multiple self. He also presents two

contrasting images of himself. The first is that of the victim which his pride prevents him from accepting but he admits in the session that he feels like a victim. The second is the image of himself as an agent. This man has strength of character. He does not want to be defeated and wants to be both productive and constructive with his life. In fact this seems very much a discourse of an autonomous agent. The client draws on the social discourses of gender and race as he positions himself within a wider social and political context. His view of himself is predominantly that of a black man who has suffered within the context in which he lives; a not unusual discourse for that historical period.

6.2.1.2 Discourses of power

The third theme identified in the analysis of client and therapist narratives was that relating to the discourse of power drawn upon by the participants. The non-powerful rhetoric of the person-centred model prevents the use of overtly powerful discourses within the therapist narrative and consistent with the aim of client empowerment the therapist appears to give power to the client. However, it is argued here that power remains firmly with the therapist throughout this session. The therapist actually draws upon his role as expert and the authoritative power within that role. It is signalled in the use of interpretative strategies, the permission-giving discourse and the unusual verbal behaviour of talking as the client. Although offered power by the therapist the predominant theme in the client's discourse is powerlessness. This applies at both the level of the therapeutic relationship and in his lifeworld experiences. As mentioned above he presents himself as a victim of the system, he is trapped and restricted in the choices available to him. He is unsure of the rules which he has to abide by in order to be accepted. The same applies to the therapeutic relationship. He indicates a number of times that he feels there are expectations of him or rules of the interaction; that he is unsure about and over which he has no control. He also positions the therapist as

expert by suggesting that he will already know what is inside the client's mind or that he might have the power to exorcise the anger and hurt.

6.2.1.3 Fields of Discourse

The narrative style used by speakers in conversation provides information both about the discourses they are using within the encounter and also how they are positioning themselves in relation to the other. In this encounter the therapist uses two predominant fields of discourse (Labov & Fanshell, 1977) the interview style and the person-centred style. The former follows the identification by Labov & Fanshell of a characteristic narrative within therapeutic discourse featuring a focus on discussion of emotions and the use of specialist vocabulary not present in everyday discourse. In this encounter the therapist's narrative conforms to this style but in addition he uses the specialist vocabulary and stance of the person-centred therapist. The core conditions of empathy, congruence and acceptance are apparent in the tone of voice, the lack of questions, the constant checking of understanding and the generally respectful demeanour offered to the client. In comparison the client uses three distinct fields of discourse. The first is a reaction to the interview style of the therapist in that it is an adoption of a therapeutic discourse. The client here conforms to the therapeutic agenda of discussing emotion and the idea that he is holding down emotions in a deeper part of himself. He also uses therapeutic language himself which signals the difference between this narrative and an everyday narrative. The second field of discourse adopted by the client is labelled 'making sense' and relates to the reflective self of the client. This is the style of narrative that he uses to reflect on his situation in a search for meaning. Sometimes it is recognised by specific markers such as 'it seems like' which are then followed by a monologue concerning the client's perception often of the socio-political context in which he lives. He seems here to be advancing a theory to the therapist which he would like to put on the therapeutic agenda.

The client adopts a third narrative style in the text which comprises comments on the therapeutic relationship itself. The narrative content of this discourse focuses on issues arising in the 'here and now' and often relate to the client's anxiety as to what is expected of him in this process rather than stories about his everyday experience.

6.2.1.4 Para-linguistic communication

The final theme in the analysis of client and therapist stories is the use of para-linguistic cues. Micro-analytical studies emphasise the importance of non-verbal cues in the analysis of discursive interactions. Language is mediated through facial expressions, gestures, gaze, tone of voice, intonation and so on. As mentioned previously the therapist presents almost a single voice within this interaction and his para-linguistic behaviour conforms closely with this image. He remains relatively still and maintains a stability which further reinforces his role as a listener and facilitator. In particular, the therapist nods quite emphatically in response to episodes where the client is conforming to the therapeutic agenda. This works as both a shaper of the client's utterances and a signal of understanding and encouragement. Exceptions to this include his use of eye-contact, particularly during periods of silence which add to the discomfort experienced by the client. When viewed on the film, these come across as quite threatening stares. There are a few occasions where the non-verbal cues reveal a level of discomfort is being experienced by the therapist. The specific signs include a lack of eye contact, an increase in hesitation within the speech and an increase in displacement gestures. These signals are particularly evident when the therapist is expressing a challenge to the client. The client's narrative contains a much greater range of para-linguistic communication. The client is much more uncomfortable in this situation than the therapist as evidenced by the four examples drawn out in the analysis. The mitigating devices of humour and metaphor serve the function of distancing the client from his distress but also fulfil the requirement for 'politeness' (Fairclough, 1992) within the discourse. His role does

not offer the possibility of direct rudeness or anger so therefore these feelings must be mitigated or repressed. The client displays many verbal tags within his speech which indicate a level of anxiety and conform to Fairclough's notion of negative politeness whereby the client prefaces his view with a submissive tag such as 'I don't know if this is right'. The client's distress increases at certain points in the session as indicated by the increase in non-verbal signs of distress such as avoidance of eye-contact, drinking water, hand wringing, hesitation and so on. These correspond with the therapist challenges and the frustration of the client in not being heard by the therapist.

6.2.2 Comparison of strategies used by client and therapist to manage the encounter

Section three of the analysis provides the results of an analysis of the discursive strategies used by both client and therapist to manage the encounter. This demonstrates a number of aspects of the interaction. It shows the difference in strategies used by client and therapist; it shows the effect of the strategies, which are successful and which not; it shows the dynamic within the interaction between the two participants and the way that the talk is managed as a result of these strategies. There are two main functions of these interactional strategies. One is to exercise control over the therapeutic agenda. Client and therapist use language to construct the meaning of the session in their own way. The second function is a relational one. In order for the encounter to continue the relationship between the participants must be maintained and interactional strategies provide a cement which allows the therapy to continue.

In total ten strategies were identified within the analysis, some of which were used only by one participant and others by both.

6.2.2.1 Therapist only strategies

There are three strategies which the therapist employs but the client does not. They are, reflection, interpretation and 'talking as the client'. The first two strategies are part of the therapeutic discourse, the first from within a person-centred model and the second

from within the discourse of the therapist role. The third strategy is not an obvious therapeutic technique but may be used by the therapist to communicate empathy to the client in the sense that by using the personal pronoun he is speaking from within the client's world as is the aim of person-centred therapy. However, this also may be interpreted as a violation of the individual. It removes power from the client and the result, as described in the analysis, is often that there is a breakdown of empathy within the relationship. It is a strategy which is not successful in achieving the aim of building the relationship through the use of empathy but is successful in exerting power over the client in a subtle manner.

The strategy of reflection is also a technique used within the person-centred discourse to communicate an empathic understanding of the client's narrative. However, the therapist does not reflect back the client's utterances in a non-discriminatory fashion but rather selects those part of the narrative which are considered most relevant to the aims of the therapeutic discourse. In this way it is a means of shaping the client's verbal behaviour and is also a way in which power is exerted over the client by the therapist. In this session the therapist reflects back the utterances relating to expression of emotion and self-agency, both of which are privileged discourses within the person-centred model. Other aspects of the client's narrative such as his concern about the way he has been treated by others or his desire to be constructive and make sense of his life are not reflected back as they are not part of the required intra-psychic discourse.

The final strategy used by the therapist only is that of interpretation. This is part of a general therapeutic discourse but not a person-centred discourse which claims to facilitate the client in making his own interpretations rather than impose an expert opinion on the client's narrative. However, the therapist does offer interpretations disguised as summaries or clarifications. These tend to focus on the client's awareness of his emotions. So, although the client's narrative may include many topics which

could be relevant to the direction of the therapy these are often ignored and the therapist presents a formulation of what he feels is actually going on. The sense here is that although the client has presented many possibilities in his own exploration of his situation the therapist, by virtue of his expertise, is able to select those parts that are appropriate topics for the therapeutic agenda. In other therapeutic models, particularly psychoanalysis, this technique is the essence of the therapeutic work and is seen to be the skill of the therapist. However, the person-centred model's denial of therapist expertise does not allow this factor to be explicit. It is argued here that the therapist is still using his expertise over the client but in an implicit manner.

6.2.2.2 Client only strategies

There is only one technique identified as used by the client and not the therapist in this session and it is that of resistance. The client resists the therapeutic agenda of getting in touch with his emotions throughout the session in a number of ways including stating that he doesn't want to be angry, he doesn't know how to be angry and he doesn't see any value in being angry. All of these attempts at resistance are mitigated by non-confrontative non-verbal behaviour and sometimes with humour. The client is expressing his lack of confidence in the therapeutic agenda, he is not sure that the root of his problems are his inability to contact his emotional side. In fact the client in the session does become quite angry when he talks about having to deal with mixed messages from other people. The therapist, however, does not respond to this as an example of anger because it does not conform to the therapeutic agenda. All of the client's attempts at resisting the therapeutic agenda are thwarted by the therapist who continues with the therapeutic agenda regardless or challenges the client about his denial of the emotion.

6.2.2.3 Strategies used by both client and therapist

The other seven strategies identified in this analysis are used by both the client and

the therapist but often in different ways.

Asking direct questions is not a common therapeutic strategy and is explicitly unacceptable within the person-centred model. However there are a few examples in the session where questions are asked by both the therapist and the client. The therapist questions tend to be linked to the development of empathy within the relationship. They are associated with checking the accuracy of the therapist's understanding but they also serve the function of appearing to empower the client. The therapist is taking an almost submissive role in the relationship here. However, toward the end of the session he directly asks the client to list the themes of his crying. This is uncharacteristic of the therapist's style in this session and may indicate a frustration with the client's failure to comply completely with the agenda although again the client in the preceding utterance has been demonstrating the extent of his sorrow. The effect of the question is a period of silence before the client continues to talk about the sadness in his life.

The most common question asked by the client in the session is 'y'know what I mean'. It is in the form of a linguistic tag and may be a part of the client's idiom. However, the function of the phrase does appear to change within the session. In places it is used to check the therapist's understanding of his narrative. He is checking if the therapist can really share his reality. In other places it is more emphatic, accompanied by non-verbal signals such as maintenance of eye contact indicating that this is something really important to the client and he wants his message to be heard. As with the therapist, the client only delivers one direct question which is in the form of a challenge when he asks the therapist if he really believes what he has just said. This may be a challenge to the therapist's congruence or it may be a rhetorical question, an expression of disbelief as it occurs at the end of a long episode when the client and therapist are battling for control of the session.

Congruence itself is a strategy used by both client and therapist. It refers to

communications that reveal how the speaker is feeling at that time. It is part of the person-centred discourse used to promote equality between the therapist and client. The therapist uses this technique to exert power over the client by saying that he feels it is appropriate for the client to express his emotions in the session. This is almost an order and is presented as permission giving. For the client who occupies an inferior position in this relationship by virtue of the therapeutic roles an expression of congruence delivered in this way is a powerful force. The client feels under an obligation to comply. The relative lack of congruent remarks made by the therapist in this session is interesting. It is difficult to get a sense for the therapist's true feelings as he tends to stay within his formal role.

The client on the other hand speaks of his feelings more regularly. He mentions his uncertainty about the process, he emphasises that he really wants to say something and so on. By revealing himself in this way he is complying with the client role in the relationship but being open also renders him more vulnerable.

Although challenging is not an explicit technique endorsed by the person-centred approach the therapist does use this strategy within the session to focus the client on the therapeutic agenda. This is a more overt use of power than many of the therapist strategies and risks the breakdown of the empathy created within the relationship. The client resists the challenge and the therapist reasserts his challenge a number of times. The client's silence and non-verbal communication signal his distress in these episodes. He does not feel in control but rather coerced into a position that he does not feel is productive.

Despite the relative powerlessness of the client's position he is also able to challenge the therapist a number of times in the session. He questions the genuineness of the therapist by asking the direct question mentioned above. He is asking the therapist to be congruent, to move out of his role but the therapist blanks the question and a period

of silence ensues. A second challenge occurs when he explicitly refers to the therapist's expertise by stating that the therapist may know more than the client but is keeping it from him. This is a direct challenge to the therapist's power and indicates that the client is aware of the power imbalance. However it is mitigated with humour and a displacement activity which reduces the risk factor involved in making such a challenge. The therapist responds by denying the challenge.

In the analysis of conversation the utterances which surround the language are considered to be relevant to the dialogue in that they mediate the meaning of the words themselves. In therapeutic discourse this has been termed back-channel communication (Kogan, 1998). Conversation never flows as smoothly as a written speech might and the hesitations and non-linguistic utterances indicate something of the deeper meanings within the narrative. The therapist offers much by way of reinforcing utterances such as 'mm mm' and aah' as the client speaks. These tend to occur more frequently around the parts of the client's narrative that conform to the therapeutic agenda. When the client is delivering a monologue which deviates from this agenda these utterances become less frequent. In this way this back-channel communication serves as a form of reinforcement. The client tends to use idiomatic phrases as back-channel communication, specifically, the term 'y'know' or 'for sure'. These fulfil a different function in that they signal compliance to the therapeutic agenda and are another form of mitigating device. They serve relational functions rather than therapeutic ones.

Para-linguistic signals comprise a wider category of non-verbal communication which, like back-channel communication, mediate the meaning of the spoken utterance and also serves a relational function within the therapeutic relationship. In this session humour is used as a mitigating device by the client on a number of occasions as mentioned above and serves to keep the tone of the relationship 'friendly'. When delivering a challenge both therapist and client cover the risk by smiling and using a

‘joke’ format. The client also relies on humour to resist the therapist’s challenge, in this way he deflects the narrative and is able to make a transformational shift but still maintains the relationship with the client. The therapist on occasion responds to the client’s humour in a reciprocal manner, they laugh together. The client signals his discomfort and avoidance of the therapeutic agenda by non-verbal communication such as avoidance of eye contact, drinking water, shifting position and so on. Likewise the therapist when challenging the client or offering an interpretation that may be risky shows similar signs of discomfort. Para-language also signals the utterances that are meaningful to the client. When he wants to be understood he signals the importance of his utterance with direct eye contact, a forward position in the chair and uses less tag phrases and hesitations. Equally the therapist emphasises statements that are meaningful to him in much the same manner. It is difficult to know the impact of these para-linguistic cues but it is extremely likely that both participants in the dialogue are responding to each other at this level whether it is conscious or unconscious.

The final theme identified in this stage of the analysis is that of silence. As indicated in the analysis section the session contains two fairly long periods of silence lasting for eighteen seconds each. In both cases the client shows obvious signs of discomfort and appears to be dealing with tensions within himself. The therapist offers no intervention throughout the silence but continues to stare at the client. This comes across as a very powerful strategy – almost a battle of wills. In both cases the therapist wins and the client conforms to the therapeutic agenda. The power of silence is a recognised phenomenon within therapeutic discourse but in the person centred approach silence is interpreted as the time when the client gets close to his emotions. It is understood as difficult but always as intra-psychic. The notion that the therapist may be exerting power through the silence or by letting the silence continue is not addressed within this model.

6.2.3. Evidence for the presence of a parallel process within the client's narrative.

The final section of the analysis offers a departure from the traditional readings of therapy talk as adhered to in the previous sections. The analyses considered so far indicate that the client and therapist are entering this encounter with different stories to tell and different goals for the therapeutic agenda and far from power being absent from the interaction, the strategies that they each employ can be seen as attempts to control the therapeutic agenda and to manage the relationship. However, it is argued here that ultimately the power differential in any therapeutic encounter is shifted in the direction of the therapist by virtue of how that role is positioned within the therapeutic discourse. The client is therefore positioned by the therapeutic discourse in a position of powerlessness just because he is the client. If we then consider wider social discourses we can see that in terms of class, age, race, education and status the client is again positioned in a less powerful position than the therapist in relation to each of these. Against this backdrop, person-centred therapy advances a rhetoric of equality and mutuality within the therapeutic relationship, suggesting that it is possible somehow to remove the discourses of power outlined above from the person-centred therapy session. This analysis shows that those discourses are still operating within this session and there is little evidence of an equality of power between therapist and client. However the discourse of equality means that there is no language to confront issues of power within this therapeutic encounter in the same way that a culture which denies the existence of, say, child sexual abuse, will not need a language through which to discuss its implications. If it is assumed that power issues are not a part of the process then any comments relating to inequality or lack of reciprocity will not be heard, they are not part of the privileged discourse. Therefore, it is necessary for the client to find an alternative way to express the thoughts and feelings that are denied within the therapeutic discourse. It is suggested here that the client does indeed do so in a very subtle

manner which can be understood within the theoretical ideas of Michel de Certeau (1984) regarding resistance to cultural tools such as language. He makes the analogy with the Spanish colonisers who imposed their own culture on the indigenous Indians but the Indians, while appearing to consent to this imposition actually appropriated the cultural tools of the coloniser and subverted them to meet their own ends. They used the dominant social order to deflect its power without resisting it in an overt way. In this manner we could make sense of the way that the client here appropriates the cultural tool of language and through the use of parallel process subvert it in order to make his voice heard.

Thus, this analysis looks at another level of communication which is termed a parallel process as it appears to resemble the process acknowledged within psychoanalysis whereby characteristics of one process are reflected in a different one. For example when a supervisory encounter begins to resemble the therapeutic encounter which the therapist has brought to the supervisor. The issue of whether this process is unconscious or not is not pertinent to the current discussion it is merely presented as an alternative reading of the text.

The client's narrative includes a number of themes which can be read as a comment on his everyday life but also as a comment on his feelings about the therapeutic relationship itself. If read as a sub-text it is possible to see that the client is expressing some quite strong emotions about the therapeutic process.

Close to the beginning of the session the client speaks about being trapped and having limited options suggesting that he has concerns from the start that he will be out of control in this process and that the options available to him are already limited by the 'system' in this case the therapeutic discourse. He mentions the issue of trust a number of times in the session. Firstly in an utterance about trusting in himself more than in his experiences and later asking the rhetorical question – how can he trust someone

enough to reveal his hurt. This theme presents the client as someone who has had bad experiences of trusting others and feels happier relying upon himself rather than others, he is a proud and a strong man. The second utterance may be read as a direct challenge to the therapist – how can I trust someone enough? It may be asking the therapist if he is trustworthy or it may be challenging the process which is theoretically based on trust. As the pressure has been on the client throughout the session to reveal his emotions this may be a response which explains his resistance – he does not trust the process enough. This hypothesis is backed up by the later comment (26.25) that he doesn't trust that it's been worth it. If read as a sub text the client may be expressing his dissatisfaction with the interview. It is argued here that the client's narrative focuses on issues of living and his search for meaning and understanding in his life. A dominant theme in his narrative is that his culture has treated him badly and caused him to suffer. It is implied, although not stated, that the suffering relates to racism. The client, as described earlier, is a young black man, not apparently wealthy or professional and the therapist is an older, professional, middle-class white man. In fact it could be said that the therapist is a good representative of the culture which is responsible for the client's experiences in his life. The client mentions the notion of representation when he talks about his desire to find just one person that he could blame for what has happened to him. This may be an example of an entirely different relationship between client and therapist that cannot be overly expressed. The idea is repeated more forcefully when he speaks of seeing the whole culture represented in one man. The client makes a number of comments about relationship within his narrative. If taken to refer to the therapeutic relationship rather than the relationship mentioned in the narrative he is expressing a desire for mutuality and reciprocity and feels that he has tried as hard as he can but is not getting anything back, that he has been a failure in relationships. In terms of the person-centred discourse it is interesting that the healing factor is said to be the relationship itself yet here is a

client who is saying that he has not experienced the relationship as mutual and is frustrated that he has been working hard and had very little back in return. From the analysis it can be seen that it is the client who has worked hard in this session, who has been open and congruent and genuine and the therapist who has offered little of value. It does not come across as a mutual relationship. In fact the client's bad experiences of relationships in his everyday life have been reinforced here by having another bad relationship experience.

In the analysis, three episodes from the session are analysed in detail. It is not necessary to repeat these findings here. The first example if read as a direct communication about the therapeutic process is a very strong attack on the process itself. The client is speaking at the therapist in an attacking manner, he is agitated and emphatic. The episode ends with the client saying he doesn't want to be treated like this anymore. The theme of the attack is the mixed messages or 'two-faced' behaviour that he is experiencing. He feels that he is not being treated in a genuine way and is not being accepted. The episode is tagged as parallel process by the use of the term 'professional' twice at the beginning. The client directs his attack at professional people in a professional situation which is the situation in which he currently finds himself. He is indicating that the therapist is failing to be direct and open with him and is warning him off in a fairly strong way. The struggle for power within the relationship continues for a few minutes after this episode ending with the first of the long silences.

The other two examples demonstrate the themes of representation and mutuality discussed above.

6.3 Issues arising from interpretation of results

The analysis and discussion of results presented above has argued that when this text is analysed with respect to issues of power it is possible to read the material in a different way; a way that positions the therapist and client as protagonists within a dialogical

battle for control over the agenda and the relationship. This is achieved by constructing the framing concept of levels of communication occurring within the dialogue. Such a notion is consistent with therapeutic paradigms, including that of Carl Rogers. For Rogers the individual can operate from the level of the experiential self or from the deeper level of the organismic self. This Rogerian framework, however, is value laden in that the aim of therapy is to promote the preferred mode of functioning (i.e. from the organismic self). Within the operation of the therapeutic encounter the person-centred rhetoric promotes the notion that underneath the client's words lies a deeper level of meaning which can be heard by an empathic and motivated therapist. The argument within this research is not that different levels and meanings do not exist in discourse but that there is no value in a notion of a 'true' or 'real' meaning which can be revealed through the skills of a genuine, empathic and congruent therapist. Rather, this research has borrowed the post-modernist rhetoric of narratives and discourse in order to offer a different lens through which this therapeutic encounter can be observed. If it is understood that talk is not referential or representational then the content of speech is not the important criterion for understanding. The functional units of talk are not statements or utterances made by the speaker but rather the parts of speech that are accepted by speaker and listener as relevant. Thus it is an interactional unit not a conversational unit which is basic to talk (Goffman, 1974). The sequences of changes in the frames for events or what Goffman refers to as 'footing' is crucial to the construction of meaning. An interaction involves a relationship moving along a number of dimensions managed by devices such as challenges, defences and retreats not requests and assertions (Labov & Fanshell, 1997). When a conversation is structured according to the rules of therapeutic discourse there are constraints on what can be said and what can be heard. This is partly to do with role alignment and the acceptable conversational formats associated with the roles of therapist and client. It is also

because therapy operates within a number of discursive frameworks such as therapy models, psychological theories, medical diagnostic classifications, professional relationships and codes of practice which all impose constraints on the relationship and the shape of the interaction, (Fish, 1999). Parker, following Foucault, sees the therapeutic discourse as offering only certain conditions of possibility to the client. In Western culture this discourse is based on psychological models of the self which position psychological distress within the intra-psychic domain to the exclusion of the social and political context and thereby make the client responsible for resolving his own problems through the confessional technique (Foucault, 1981; Parker 1998). The client's agenda in this session draws on discourses of masculinity, race, victimisation and alienation. His anger and hurt is located in the environment in which he lives and the way that he has been treated by others within a social and political system. However within the discursive framework of the Rogerian model problems are rooted in the intra-psychic – in the individual's alienation from his 'real' self and it is not within the conditions of possibility for the client to present an alternative story. The client's attempts to define his problem within his own agenda are thwarted by the therapist throughout the session and gradually the problem is redefined as intrapsychic and 'truth' is reconstructed.

From a post-modern perspective it is possible to unravel (or deconstruct) the levels within the discourse and also to position these levels (or voices) within a social and political discourse. In this way it is now possible to see the therapist and the client arriving at the therapy room as individuals who are products of their position, experience, education, race, class, personality and so on. In this particular session these worlds are very far apart from each other and if the task of person-centred therapy is for the therapist to enter the client's world there is a lot of work to do. My argument here, is that the therapist is unable to achieve this goal because the therapeutic discourse

within which he is positioned limits the possibilities open to him. The client's story is a moral one. It is to do with making sense of his experiences, finding a value and reason for his life. In the context of a man who has faced death these are not unusual existential issues. Taylor (1989) argues that identity and morality are tightly linked and identities are created in a social, political and historical context which are based on moral values. The theme of 'the right thing' runs throughout the client's narrative. Johnson (1993) argues that moral reasoning is a constructive imaginative activity based on metaphoric concepts such as freedom, rights, duties and so on and that these are used within a common cultural understanding. The client is from a different cultural background to the therapist by virtue of his race and social standing. His concepts of morality may not be shared. Emotion, Riikonen and Smith (1997) suggest, is also culturally defined. This is apparent in the session when the client talks about angry blacks being seen as militant and again when he talks about the reasons that it is not acceptable to cry. To get in touch with emotion and express feelings as demanded by a therapeutic discourse is at odds with the discourses within which the client is already positioned. In order to connect with the client the therapist must have some understanding of the constraints already existing around himself and the client.

A relationship, as envisaged in a person-centred paradigm, is a chimera of the concept. Not only is the issue of the power dynamic denied and therefore not articulated, a discussion of the vast range of functions of language in talk is not explored and no mechanism for its discussion is provided. The therapeutic relationship is dialogic, facilitative, reciprocal, co-operative, collusive, combative, abusive, antagonistic and so on.. Within a person-centred discourse it is represented as simplistic and 'one-way'. Such a representation allows for the operation of a power discourse which is not acknowledged or worked with as part of the therapeutic process. A client in such a system is limited in the ways in which they can be heard. Clients bring stories of their

lifeworld to therapy. It is this world which creates meaning for most individuals and it is this which must be the focus of the therapeutic encounter if it is to be a meaningful experience for the client. Therapy can be a form of rhetorical persuasion and this is certainly a discourse which has been identified as a subtle process within this material, but if this is the case then therapy is playing the role of a social agent in subjecting clients to a normalising process

6.4. Implications for practice

Any analysis of text presents a particular story about the data that is in part a function of the method of analysis. The results of the analysis also present a story which is a function of the particular theoretical models privileged in the understanding of the data. The aim of this study is not to offer a definitive reading of this material which approximates a ‘truth’ about what is occurring in this session between therapist and client. Neither is it to argue that a post-modern or social–constructionist paradigm provides a ‘better’ understanding of the process than a modernist paradigm. As a piece of research rooted in practice it aims to offer some further insight into the depths and complexities of the therapeutic relationship. By increasing awareness of the levels at which communication may be operating within a therapeutic encounter a practitioner will increase the possibilities of understanding their client’s world. By realising that the operation of power is part of interpersonal relationships of all types including therapy, practitioners can become aware of the influence of the power dynamic between themselves and their clients and consider the ways in which this can be put to therapeutic use. The roots of a successful therapeutic relationship may well lie in the effective transmission of Rogers’ core conditions but understanding the way that meaning is constructed through language provides us with a greater understanding of the mechanisms of therapeutic relationships which can only serve to enhance our practice.

At the outset of the study certain claims regarding validity of the research were made. On reflection these claims have generally been upheld. The design, procedure and analysis are described in enough detail to demonstrate the craftsmanship of the researcher and to enable the reader to consider their transferability to another situation. It would be interesting to repeat this study on a different therapeutic session and compare findings. The employment of a number of analytical techniques has enabled the analysis of a number of separate but connected elements of the situation, namely the individual narratives of the client and therapist and also the therapeutic interaction between them. The inclusion of para-linguistic data in the analysis has offered further illumination of the communication process. In retrospect a more theoretically integrated approach to the analysis would represent an improvement in the design of the study. Finally, I feel that the study is warranted in terms of widening the scope of investigations into therapeutic conversation. It provides a focus on the power dynamic within therapeutic conversation using analytic techniques which are only beginning to be used in therapeutic research. It also provides an opportunity for therapists to take a different perspective on their clinical work. One area that I think would represent an improvement in the rigour of studies of this nature would be to invite feedback from the participants themselves. Clearly this is impossible with the data chosen here as the participants are no longer with us but in future it would be possible to use contemporary data where the analysis could then be shared with the participants and a further layer of understanding could be gained.

7.0 Conclusion

This study set out to explore the themes of language and power within a therapeutic relationship. To this end the focus of the investigation was the communicative strategies adopted by both therapist and client in a particular therapy session. For the purposes

of this research the notion of power was understood as a force utilised by the participants to gain advantage within the relationship. It is not explored in any wider context here. In order to do so a particular blend of methodologies were used to analyse the therapy talk occurring within one isolated session of a therapy encounter. Through the use of these analytical tools it was revealed that the communication between therapist and client could be understood on a number of different levels and that the therapy talk served a number of functions. On the surface information was exchanged and facts were presented but at deeper levels, talk was used as a means to control the relationship itself and the positions of the players within the interaction.

Critics may question the relevance of such an approach for practitioners and may believe that there is nothing to be gained from understanding the therapeutic process in this way. However, most practitioners would agree that it is useful to understand something about therapeutic process in order to understand clients and their issues. By analysing text in the manner demonstrated here it is possible to explore the ways in which language creates meaning within relationship and how this may offer another layer of communication within the therapeutic process. Considering the role of language in relationship may provide a useful framework for practitioners reflecting on their therapeutic work. It may also provide an additional dimension to the analysis of therapeutic process.

As psychotherapy has always been a predominantly language based intervention it is interesting how little we as therapists know of the study of language. The wealth of knowledge gained within the fields of literary criticism, linguistics, critical theory, philosophy and so on relating to language can provide a useful source of alternative perspectives on therapeutic talk. It is interesting that most of the analytic research on therapy talk has not been conducted by therapists themselves. This may be an area for

further research within the profession.

The concept of power within psychotherapy is always interpreted in a negative frame. It has become associated with notions of abuse and therapists wielding power are considered to be malevolent, unprofessional and unacceptable. Whilst acknowledging that therapists must work within their codes of ethical practice it must also be recognised that to claim that a power dynamic does not exist within therapeutic relationships is naïve and also unprofessional. Understood as an inevitable part of any relationship, power, no longer needs to be labelled as a negative force but as an active ingredient in the complex mix that makes relationships (including therapeutic relationships) so interesting. By failing to consider the role that power plays in the relationship between therapist and client it is possible that vital aspects of the therapeutic process are missed. It has also been a common misconception that clients are powerless in therapy and in fact the aims of many therapeutic approaches are to ‘empower’ clients. This study has shown that the therapist in this particular encounter did indeed possess more power than the client and adopted strategies to maintain this advantage throughout the session. However it also shows that the client is not powerless but does in fact adopt strategies to increase his power base and can be seen as a powerful player in the ‘game’. Although therapy may aim to facilitate clients to become ‘empowered’ in their everyday lives, they are not encouraged to demonstrate their power within therapy sessions.

The study also shows that a therapeutic encounter may be perceived and understood as a game of strategy with clear rules and boundaries which cannot be transgressed. The odds are often stacked against the client at the beginning of the interaction as the rules are implicit and only become clear as the relationship develops. These rules are not the explicit type which form the basis of therapeutic contracts but rather, are the implicit

rules of relationships where both protagonists are vying for control. They may not be conscious to either the client or therapist but they do have a functional role to play in the outcome of therapy. The notion that clients are free to explore issues as they arise in whatever way they wish in a therapeutic session is at best a naïve understanding of the way that relationships work and at worst a great disservice to the client.

The particular findings of this study are not deemed to be of value in themselves. As stated in the methodology section, any findings from analysis of texts must be dependent to some extent on the methods of analysis used to interpret the data and also on the theoretical frame used by the researcher to inform her view. The material presented here could be analysed by a different researcher using a different technique and the findings may be different. This study presents one view and one voice. It may be a perspective that some find illuminating while others may not. What is of more value from studies such as these is the general point that text provides an endless source on information about the manner in which people relate and the strategies they use to develop, maintain and end relationships in many different contexts. The more ways in which this material can be studied and the more theories that are advanced as a result the richer the understanding of interpersonal relationships will become. As a result more possible understandings of those in distress can be generated and potential interventions found.

Therapists claim that the therapeutic relationship is the effective factor in therapeutic success. Independent of therapeutic orientation it is claimed that what works for clients is their perception of being ‘heard’ and understood by their therapist. The value of research such as this for practitioners is that it provides a philosophical ethos and methodological approach that enables a deeper understanding of what that actually means in reality. If therapy is indeed a constrained and boundaried enterprise this

does not mean that it should be valued less but invalid claims suggesting that ‘anything goes’ should be considered to be unacceptable. A recognition that contextual and personal constraints do govern therapeutic encounters should lead to a deeper exploration of the mechanisms by which these processes work and eventually more effective therapeutic interventions.

8.0 Reflexivity

‘what can be said at all can be said clearly, and what we cannot talk about we must pass over in silence’ (Wittgenstein 1961:3).

This project grew from a long-standing interest in the topics of power in therapy and interpersonal relationships. A few years ago I began some research for a PhD on relationships between couples and the notion of a dynamic of power which changed over the duration of the relationship. Unfortunately, I was unable to continue with that particular project at the time due to other work commitments. However, the interest in the area has stayed with me. As a practising counselling psychologist I have been aware for some time of a power dynamic in my work with clients. As my work is influenced mainly by a humanistic paradigm I found it difficult to reconcile my experiences of power and my theoretical stance on equality within relationship. In recent years I began to take a much more critical attitude to the work of Carl Rogers and have reflected on the difficulties inherent in this approach at both the level of practise and theory.

Having studied philosophy as an undergraduate student I have always enjoyed pushing the boundaries of psychology a little in the philosophical direction. The writings of the post-modern movement had a great impact on my thinking as they did on many others. However, my initial enchantment with these ideas turned a little sceptical as I read more deeply. Although this project has been heavily influenced by a post-modern approach I hope it does not come across as the work of a convert. I have found this way of looking at the world novel and exciting and it has helped me to get rid of some of the dinosaurs that were inhibiting my thinking. However, I also see the limits to adopting the model completely and will always hold a sceptical view.

In reading for the literature review I found myself absorbed and pulled back into some of the most interesting and fascinating areas of study. It was a struggle to keep a focus

on my topic and refrain from delving deeper into the realms of literary criticism and linguistics. These are areas to which I shall return in the future and ones from which I feel psychology has much to gain.

My research into microanalytic techniques as a means to understand talk also brought me into a new arena. I was amazed at the work of conversation analysts and very excited about adopting some of the techniques myself.

I have viewed the film of my chosen material so many times I know the text by heart now but every-time I have listened or watched the film again I have seen something else that I missed before. Although I do not know the client or anything about him I feel almost intimate with him now. I have enormous respect for him as an individual and often wonder what happened to him. If he were still alive I would like to thank him for the privilege of using this material.

This project has been difficult and tiring. It has taken much longer than it should and I have had a number of crises on the way. However, it has been a wonderful experience. I feel proud of my work, I have enjoyed pushing myself to think about difficult topics and I have appreciated the discussions with my supervisor. I intend to carry on with this type of work and apply this approach to the analysis of therapy talk in other ways. If the most important aspect of being human is relationships with others then the way in which we use language to maintain and control those relationships is a critical area of study.

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(These references follow the British Psychological Society's style format)

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Appendix

Carl Rogers Counsels an Individual on Anger and Hurt: Part 1 Second Interview with Client.

AACD

Transcript notation follows Gail Jefferson (1984)

C=Client

R=Rogers

Ref: Counter Number	Transcript
0000.52 0000.55	R OK,(2.2) where do you want to start this morning?
0000.57 0001.02 0001.04 0001.06	C I don't know, I was thinking that (1.2) when we talked earlier about the the anger (.) I've been thinking a great deal about that =
0001.07 0001.09	R =I've thought a lot about what you had to say about that [mm]
0001.11 0001.12 0001.17 0001.20 0001.21 0001.23 0001.24 0001.26 0001.31 0001.33 0001.34 0001.36 0001.37 0001.40 0001.42 0001.44 0001.46	C [Right]. Y'know and I'm not sure that ah (2.5) ((looking away)) that I really don't want to be angry (.) y'know and I'm not sure ((looking away)) if ang:er (.) being angry now is ((eye contact)) a (.) part of the <u>process</u> and I've got to do that ((shuffling)) and I'd <u>li:ke</u> to (.) I guess my (3) ((looking away)) my er mind ((pointing to head)) er academically or something y'know something other than emotion y'know like would like to tell me not to be angry and to skip over that part if that's a part of the process <u>y'know</u> (1)but I'm not sure ((laughs)) if I can do that y'know? ((looks down))
0001.48 0001.50 0001.53	R Your mind says you're to, oh, cool it, don't don't get (1.5) into eh strong emotion =
0001.54 0001.55 0001.58 0002.00 0002.01 0002.04 0002.06 0002.10 0002.11	C ((nodding))=For sure, it almost seems like <u>that</u> (1) ((looks down)) whatever is ha:ppening in my environment or whatever happened in my environment is pulling me into, <u>again</u> (1.5) aah that kind of a <u>trap</u> ((eye contact)) that kind of a system that (.) I don't particularly <u>ca:re</u> (2) y'know ((shaking head)) if you know what I mean=
0002.11 0002.13 0002.14	R =I think I get that that your ((hand gesture)) (1) your <u>mind</u> is taking the pla:ce of the system and saying now

0002.17 0002.19		oh (4) ((pushes hands away)) play it right, do the right do the proper thing
0002.20	C	Right
0002.21 0002.23	R	But some other part of you is saying 'yeah but there's some anger there'.
0002.25	C	[For sure, for sure]
0002.25	R	[There's some real] anger there ((nodding))
0002.27 0002.29 0002.30 0002.31 0002.33 0002.35 0002.37 0002.39 0002.41 0002.43 0002.47 0002.48 0002.51	C	Its, its <u>almost</u> like in this co:untry- ((looks away)) (1) and, and I've always felt like this you only have about two ((eye contact)) options, y'know when you deal with <u>race</u> -(2) eh you either have to b:e (1) you're either a racist- or you're an anti-racist. That dosen't really seem to be the kind of thing that I (1) I y'know I don't really <u>care</u> to be an anti-racist if y'know what I mean anymore (1) aaah and I don't <u>want</u> to be a reflection of any other y'know <u>larger</u> society at all (.) I really don't want it.=
0002.54 0002.55	R	=You'd (.) like to get in touch with whats going on in [<u>you</u>]=
0002.57	C	=[For sure]
0002.58	R	Not some label or other
0003.00 0003.02 0003.05 0003.07	C	For sure (3) I think that I could probably trust <u>that</u> (.) a lot better than than trusting whats happening or what has [happened],
	R	[mm mm]
0003.09 0003.11 0003.13 0003.15 0003.19 0003.21	C	And, em when I <u>think</u> about that when I (looks away) <u>think</u> about all of that em y'know (2) things that we talked about I I (eye contact) think, that em (3) thats worse than the leukaemia (smiling) (.) [y'know]
0003.21	R	[A ha]
0003.23 0003.24 0003.26	C	that may sound (shrugging) very strange (nodding) or whatever but a <u>lot of things</u> have been strange (emphatic nodding)
0003.27	R	[mm mm]
0003.28 0003.30 0003.32 0003.35	C	[Y'know] since this time and what has <u>happened</u> to me didn't just start (1) when I found out that I ((shrugs)) y'know (2) was going to die=
0003.36	R	=[mm mm]=
0003.37	C	=[kind of thing]
0003.39 0003.40 0003.44 0003.45 0003.47	R	Let me see if I understand that that you feel as though (.) em (2) what the culture and people and so on have,have <u>done</u> ((pushing hands away)) to you has really caused you more <u>suffering</u> than the leukaemia is that

0003.49		what you're saying?
0003.51 0003.53 0003.56 0004.00 0004.02 0004.04 0004.05	C	I think so (.) I think so (.) and to some extent that would (.) that is <u>mild</u> like for instance (2) y'know (.) I don't <u>know</u> what would happen if I had've (.) <u>died</u> (1) or if I will or whatever but I certainly know what is happening now and what <u>happened</u> . (1) you see
0004.08	R	mm mmm
0004.09 0004.11 0004.14 0004.16 0004.17	C R	and to some extent that <u>kind</u> of leukaemia that kind of (.) <u>deterioration</u> of the <u>body</u> is the same kind of thing that happened to my [mind] (nod) [mm mm]
0004.18	C	and emmm (2) [y'know its just]=
0004.21 0004.22	R	=[So really] what the culture did to you was give you a cancer of the mind
0004.25 0004.29 0004.32 0004.33 0004.36 0004.39 0004.41 0004.44 0004.46 0004.47 0004.50 0004.52 0004.53 0004.54 0004.55	C R	Yeah I I I <u>really</u> want to say that ((looks away)) and I really want to (2) and I believe (eye contact) it y'know and I guess that part of me (.) thats my culture and its a part of the total is saying that its not all that good to be angry (.) y'know () because militancy is frowned upon or whatever y'know and I guess ((looks away)) I'm using ((looks away)) militant in my sense because of its (.) its traditionally ((shaking head)) y'know when blacks become angry they're not angry they're militant (2.5) mmhmm y'know what I mean?
0004.56	R	I know ((laugh))
0004.57	C	((laughing)) so
0004.58	R	Another label?
0004.59 0005.03 0005.05 0005.07 0005.09 0005.11 0005.13 0005.15	C	mm for sure, for sure (.) for sure (1.5) and I kee.. and theres nobody that I can put my finger on y'know that person that started the whole thing, that process y'know, because that would probably be a lot better for me y'know then I probably ((looking up))would try to (.) do (.) to do that person in,
0005.18 0005.20 0005.23 0005.25	R	((nodding)) { Yeah, if you could if you could pin it on <u>one</u> person then your rage would be <u>justified</u> and you could re:ally get after that person

0005.28 0005.30 0005.33 0005.35 0005.36 0005.38 0005.40 0005.44 0005.46 0005.48 0005.51	C	mm (.) but how do you blame somebody else's sick. (.) y'know (.) and I think that people that do that ((hand gesture)) to other people or at least the one who was done to me ((pointing to chest)) em they're really sick you know (.) and here I am y'know (1) trying to y'know I don't know if its forgiving,I don't know if I'm sounding confused or whatever (.) may (1.5) y'know (.) but (1)trying to accept their sickness (.) y'know
0005.54	R	mm
0005.55 0005.58 0005.59 0006.01	C	and at the same time y'know (.) I really haven't had the opportunity to let anybody accept mine. (.) or maybe I haven't given it to them but =
0006.02 0006.04	R	=Yeah or maybe you haven't given it to them= ((emphatic nodding))
0006.04	C	=Right
0006.05 0006.07 0006.10 0006.14 0006.15	R	Thats what I sense is going on (.) now that you feel (2) 'theres so many reasons why I really shouldn't eh express my anger I'll, (shaking head) I'll talk about all those reasons' (smiles)
0006.19 0006.21 0006.23 0006.26 0006.28 0006.29 0006.32 0006.37 0006.39 0006.43	C	Yeah (laughing) for sure (laughs, moves position) (2) I don't know really (1) y'know (.) if (2)(claps hands on legs) maybe I'll just be angry one day (laughing) and maybe I'll really feel better or whatever y'know and and <u>When</u> I smile I'm aah (3) y'know (lifts hand) I'm smiling but (.) there's a a lot of (.) I'm sure you know that (looks down) (.) theres a lot of anger there=
0006.44	R	mm
0006.45 0006.49	C R SILENCE (5)	 its not my nature to be angry but I feel angry
0006.53 0006.56 0006.59 0007.01	R	Yeah mm and eh (2) so I hear you <u>explaining</u> and explaining (2) that eh 'its not my nature to be angry its just that I am angry right now'

0007.02 0007.06 0007.08 0007.09 0007.11 0007.12 0007.14 0007.16 0007.18 0007.20 0007.24 0007.25 0007.28 0007.30 0007.31 0007.33 0007.36 0007.38 0007.40 0007.42 0007.45 0007.47 0007.50 0007.53 0007.54 0007.58 0008.00 0008.01 0008.02	C	For sure ((laugh)) for sure (.) and I try ((shaking head)) to be angry in a productive way I don't know how (eye contact) you be angry in a productive way y'know? in terms of (1). Its like <u>no:w</u> when I when I (1) I respond (1) to people y'know it, it when you <u>encounter</u> people y'know whether its I:n the street ah whether its I:n ah professional situation or (.) whatever (2). Y'know if people send out certain messages (eye contact)(1) a:nd wo no matter what they're saying or whatever there are certain kinds of messages that I'm getting. (.) y'know,.They're saying that hey y'know that that isn't for me kind of thing (.) y'know. (1) and as befo:re I'd like to <u>work</u> with th:at and like to try to <u>communicate</u> without alienating (.) people or whatever but <u>now</u> y'know I begin to get upset hey thats a bunch of crap. (1) y'know don't don't tell me about the way that I should do it or or give me all that non-verbal stuff about eh (1) em saying that I'm <u>OK</u> but by non-verbally saying hey (shaking head) y'know you're really not OK and I don't want to hear that kind of stuff anymore
0008.05 0008.06 0008.07 0008.11	R	(1)((looking down)) I get what you're saying and I also <u>feel</u> quite strongly that I want to say (2) its OK((nodding emphatically)) with me if you're angry here SILENCE (5)
0008.16 0008.17 0008.18	C R	((smiling)) But I don't () y'know its hard to know(looking away)) how [to be angry] y'know? [sure, sure]
0008.19 0008.20 0008.21 0008.23 0008.25	R C R	I'm not saying you [have to be] [For sure] I'm just saying its OK with me (2) if you <u>feel</u> like being angry you can be angry
0008.26	C	You really believe that?
0008.28	R	Damn right
		SILENCE (18)

0008.51 0008.53 0008.55 0008.58 0009.01 0009.03 0009.08	C	((looking down)) I'm not sure how to respond to that at all (2) y'know (.) because a part of that anger is all the hurt and <u>maybe</u> if I <u>maybe</u> ((looking up)) whats happening is that if I become angry and I re:ally let it hang out (.) that I <u>really</u> will see how hurt I [am] (1) a:nd em
0009.12 0009.13	C	y'know that just came ((shrugging)) to me as you were talking (2) that y'know =
0009.18 0009.20 0009.21	R	=Perhaps at a deeper level you're afraid of the <u>hurt</u> you may experience if you let yourself experience the anger
0009.23	C	For sure (2)
0009.25	R	aah
0009.27 0009.37 0009.38 0009.40 0009.42 0009.44 0009.50 0009.52 0009.54	C	(2) Really (laugh) em((moving position)) (6) I keep getting these blo:cks y'know these y'know (.) when I come to something like that y'know because (.) y'know to me thats a revelation and I'm not really sure that em (4) risking being angry ((shaking head)) I guess or something like that y'know ((smiling))(2) losing control maybe
0009.55	R	yeah
0009.56	C	y'know SILENCE (14)
0010.12 0010.16 0010.18 0010.23 0010.25 0010.28	R	I really do get that that this realisation that ma:ybe what I'm most afraid of is the <u>hurt</u> that I might experience(2) em (1) makes you more ((hand gesture)) (1) cautious about whether you should or could really let go of the of the anger
		SILENCE (4)
0010.35	C	I really don't know I think that=
0010.37	R	=its a risk
0010.38 0010.41	C	Right (.) and its (1) y'know I haven't really thought about that before and...
0010.42	R	mmhh.....Its new
0010.44 0010.47 0010.50 0010.55 0010.57	C	...its aa (2) I guess I would be and I I'd really admit openly I'd been hurt I I said (2) that I've that I've been hurt and I think you know that I feel I've been hurt but(2) to really show that v'know
0011.00 0011.01 0011.06 0011.09	R	To show it ((hand gesture)) and I guess to let yourself sort of (3) exp:erience it that (3) that I guess ((nodding)) would be difficult (2)

0011.12 0011.16 0011.19 0011.21	C	Yeah, I don't know its (1) its as scary I think as the possibility of(1) that I had before, more than (.) before, about dying y'know (1)
0011.23	R	mmhh
0011.24 0011.27 0011.29 0011.31 0011.35 0011.37 0011.40 0011.42 0011.45	C	and maybe y'know (2) I was really scared because of the symptoms y'know not being able to <u>walk</u> and not being able to see and things like that y'know (1) and having to depend on somebody y'know (1) and for gods sake y'know having (.) to show somebody that I'm that I'm <u>hurt</u> ? and how can I trust that to somebody y'know (1) em
0011.48	R	Sounds like a <u>horribly</u> big risk
0011.51 0011.53	C	Yeah it is ((laughing)) It seems to be getting bigger and bigger as we talk ((looks down))
0011.58 0012.01 0012.06 0012.08 0012.09 0012.10	R	Suppose I really expose to somebody the fact that I'm (1) deeply, deeply hurt, that in a sense would be comparable to (.) having to be dependent on someone when you can't walk or something like that?
0012.14 0012.20 0012.23 0012.26 0012.28 0012.31 0012.35 0012.37 0012.38 0012.41 0012.42	C	((moves head, closes eyes, smiles)) Right (8) Yeah, I'd like to just to say thats like my condition ((laughing)) thats one way out of it.((laughing, hand to face)). But that isn't really acceptable to me now because I,I,I (1) I feel that I feel like I have to express that that hurt or whatever but y'know I can say that y'know that I know right down here y'know I'm saying that when I say it kinda keeps something down here y'know?
0012.44	R	you're saying it from here up [points to chest]
0012.46 0012.50	C	For sure, for sure [laugh] (1) I don't know how to do that exactly or whatever
		SILENCE (4)
0012.56 0012.58 0013.00 0013.03 0013.06 0013.08 0013.09 0013.11 0013.12 0013.16 0013.19 0013.21 0013.26 0013.27		Its like I don't drink a lot y'know because I don't really want to (.) experience that kind of em (1) y'know (.) Alcohol to me is a <u>depressant</u> anyway (1) and em y'know and that's ((emphasises with hand gesture))about the only thing I really like to get out (.)to really get out y'know and maybe saying y'know like I love somebody?(1) I gave her myself I did the hell best I could and it wasn't good enough (.) y'know a:nd (1) y'know demand on top of demand and everything like that

0013.31 0013.34 0013.38 0013.40 0013.44 0013.46 0013.48 0013.51 0013.54 0013.56		y'know its this (1) y'know shit y'know ((hand gesture)) its like (.) that I'd <u>like</u> to be able er (1) and I said this the other day ((hands to face)) when I was talking to you I'd like to be able to (2) to say that yeah I was <u>screwed over</u> and I got <u>hurt</u> and everything else like that or whatever but its an (1) almost an admission in a way on another level of (.) of of saying that they got the best of me
0013.57	R	mm mm
0013.58 0014.02 0014.03 0014.06	C	Y'know (.) and I really don't <u>want</u> I really don't want anybody historically to have gotten the best of me but they <u>did, they did</u> , they beat the hell out of me ((camera focus on client wringing hands))
0014.08 0014.10 0014.14	R	You don't want to say 'I really was defeated (1) at times' and yet ((shaking head)) thats the truth
0014.16	C	mm (1) it is SILENCE (8)
0014.27 0014.30 0014.32 0014.36 0014.39 0014.42 0014.43 0014.45 0014.47 0014.49 0014.51 0014.55 0014.57 0015.02 0015.04 0015.06 0015.09 0015.14		y'know (.) being,(3) having it being alright to be defeated and (.) be beaten and (.) I don't know if theres any <u>value</u> in (2) y'know maybe to myself admitting it to myself or whatever y'know but y'know that <u>I'm</u> really finding out I've got a lot of hangups ((laughing)) in terms of in that line (.) I hadn't thought of before y'know in terms of ah because I <u>don't</u> want to be beaten but I <u>was</u> y'know (.) because I think when you are hurt (.) thats being beaten (.) y'know and I <u>allow</u> myself to and I don't (.) regret caring and I don't regret loving or whatever but (.) y'know (.) like I'm a <u>kid</u> and in a way I like to be loved too I like to be (1) some reciprocity.
		SILENCE (6)
0015.20 0015.23 0015.26 0015.29	C	and I'm going to start I think expecting that (1) without being <u>cold</u> or anything like that but I have to (.) y'know start getting something back in return
0015.31	R	you want love to be mutual?
0015.32 0015.36 0015.38 0015.42 0015.46	C	For sure(.) for sure () and I don't want to have to get in the situation like I'm in <u>now</u> y'know where I'm afraid to to show anybody that I'm hurt (.) y'know scared to death, terrified
0015.49 0015.51	R	Something really <u>awful</u> about showing, letting anyone know that 'I'm hurt,=
0015.53	C	yeah

0015.54	R	=I'm hurting'
0015.56 0015.58 0015.59 0016.00 0016.02 0016.05 0016.07 0016.12 0016.13	C	Sure (.) ((looking down)) sure its (1) y'know it has something to do with being a <u>man</u> , it has something to do with (.) with the <u>race</u> ((eye contact)) thing, y'know (.) It has something to do with the <u>relationship</u> (1) maybe the failure of a relationship a (3) a <u>lot</u> of things y'know a father not being in the home with his children (5) I <u>really</u> feel like being a victim
		SILENCE(18)
0016.20		I don't know (2) how to get that up at all ((laughing, drinking water))
		SiLENCE(6)
0016.42		Every time I get close to that I take a drink of water
	R	{ Yeah ha ha ha ha } ((nodding))
0016.49 0016.51 0016.55	C	{((laughs, shifts forward & back in seat))} (3) Ha I don't know if that (.) acts to keep it down [or not]
0016.57	R	[Maybe] that'll keep it from coming up above this level ((hand gesure))
00116.58 0017.04 0017.08	C	For sure I (3) yeah its not it really isn't what I want either. I want it to get out ((hand gesture)) and stay out y'know? ((sigh))
0017.11	R	You'd like to let it out
0017.13 0017.17 0017.18 0017.21 0017.23 0017.24 0017.25 0017.26 0017.28 0017.30 0017.33 0017.36 0017.39 0017.41 0017.43	C	Yeah (2) so maybe if you ((hand gesture)) have any (.) exorcism type <u>powers</u> or whatever that err maybe ((looking down)) you can just do <u>that</u> and ((hand gestrure)) then I'll be free of that y'know (.) because that's what it feels like it feels like theres somethin there y'know that I really and I've identified it (.) I think I've identified it (.) y'know (1) because I know that sometimes when there such a big <u>lump</u> in my throat ((looking down)) (1) y'know and that I expla:in I give myself a lot of reasons why I shouldn't be feeling like that (.) y'know (.) ((looks down))
0017.47	R	A big <u>lump</u> of hurt though=
0017.49	C	= mmhm
		SILENCE (13) ((looking down))
0018.02 0018.04 0018.10 0018.12	R	and how to let that hurt come out in the open ((hand gesture)) how to let it (4) emerge and be out <u>here</u> instead of way down locked in here

0018.13 0018.22 0018.25 0018.26 0018.28 0018.32 0018.35 0018.37 0018.40	C	Right [(laugh)] (4) yeah (3) y'know I I never believe in cookbook answers (.) to anything ((shrugging)) even when I cook I don't use a cookbook I just don't believe in it (.) but em I'd <u>really</u> like (.) to be able for somebody to tell m:e to y'know maybe how to do that in about five minutes and be through like the rest of my life in peace (.)=
	R	((laughs))
0018.41	C	=y'know what I mean?
0018.42 0018.43 0018.46 0018.47	R	Sure, It'd be awfully nice if somebody could say now if you do <u>this</u> and <u>this</u> (.) all ((hand gesture)) your hurt will come out a:nd it'll be gone forever.
0018.48	C	For sure
0018.50	R	Be great wouldn't it ?
0018.51 0018.54 0018.56	C	For sure (1) mm (1) [(laugh)] I have a suspicion that maybe you <u>know</u> ((reaching for water)) somethings that I don't know ((laugh))
0018.59	R	No (.) no I'm not holding out on you SILENCE (4)
0019.05 0019.09 0019.13	C	Yeah I I believe that I I (2) it <u>feels</u> like I'm holding out on myself (.) y'know (.) hell (4) I don't know (2)
0019.18 0019.20 0019.23 0019.25 0019.27 0019.30 0019.32 0019.25	R	It goes back to some of those things you were mentioning a <u>man</u> dosen't admit he's hurt, a <u>black</u> man especially dosen't admit that he's been hurt by anything em (3) A father dosen't admit that he's been hurt by (.)being away from his children (.) Just too many things that say no no no no don't let it out SILENCE (6).
0019.45 0019.48 0019.50 0019.53 0019.55 0019.58		But inside theres the <u>hurt</u> (.) A phrase came to me a minute ago that (.) if you could <u>let</u> that out (.) I don't know if this will ring true with you or not, if you could let that out it would be the voice of the victim (1) I don't know if that makes any sense or [not but]=
0020.01 0020.02 0020.03 0020.05 0020.06 0020.07 0020.09 0020.12	C	=[Mmhm] (.) yeah I don't know what, I don't know if I have any <u>control</u> ((smiling)) over that ((shifts back and forth in seat))(.) y'know of what of what would happen y'know its like a friend of mine the other day who who helped me through my illness and (.) everything he says y'know (.) when I encountered in any other person in that (.)

0020.13 0020.16 0020.19 0020.22 0020.24 0020.28 0020.31 0020.33 0020.35 0020.38		y'know a very intelligent sort that was (.) talking a bunch of (.) intellectual garbage about (.) feelings and and things like that. (1) that ((smirking and looking left)) I <u>really</u> wanted to just to (.) y'know I really <u>saw</u> him, the society, the culture right in him y'know. And I really wanted to just kinda deck him and thats something thats not eh my nature whatever but I really [wonder what]
0020.39	R	[Just liked] ((hand emphasis)) to have <u>socked</u> him
0020.40 0020.42 0020.44 0020.46 0020.48 0020.49 0020.50 0020.55 0020.57 0021.00 0021.02 0021.05 0021.08 0021.10 0021.12 0021.13 0021.18 0021.23 0021.35 0021.27 0021.29 0021.31 0021.38 0021.43	C	Yeah, yeah and my friend said y'know one of these days, ((looking left)) he says if you (1.) if you <u>don't</u> get it together, or something he says, not if you don't get it together, but y'know one of these days you're just going to really ((eye contact)) lose it (1) y'know, y'know what I mean? (.) Its its that I want to get rid of all that stuff that (.)was done to me and not (.) have to hear all that other stuff (.) or to be able to deal with with it in a ve:ry constructive kind of a way y'know but still it <u>grinds</u> me because of all the other stuff thats happened to me and when I see other people doing it to other people whatever it grinds me and makes me angry (,) y'know. (1) and I would think that in those situations I (.) began to kind of try to strike out like y'know ((moves forward)) protecting somebody else or fight for somebody else or whatever and I'm not sure what I did for myself all those years when all that happened to me or whatever ((moves back))(4) a:nd (1) if I could cr:y and have it be [all right]
0021.45 0021.46	R	[Thats what I was thinking]. I was just thinking if you could only cry=
002148 0021.49 0021.51	C	=Yeah, if you ((laughing , looking left, shuffling)) but thats a trip y'know thats a trip like eh ((shrug))
0021.54	R	First place a <u>man</u> dosen't cry, [yeah]
0021.56	C	[yeah] for sure (.) for sure (1) thats a fact
0022.00 0022.01 0022.02	R	but I guess you're saying there are times when you have that lump in your throat and you sure as hell <u>feel</u> like crying
0022.05 0022.10 0022.13 0022.17 0022.19 0022.21 0022.24	C	For sure (.) for sure (3) ((sigh)) hell, I don't know ((laugh)) I don't know ((shrug, looks left, shakes head))(2) I don't know, maybe going to a movie one of those old ((laughs, looks upward)) y'know movies, dramas [or something like that]
002224	R	[Tear jerker?]
002225 0022.26 0022.28	C	right so that I can cry and have an excuse to cry y'know but crying for myself I'm not sure that em (.) just not sure thats going to be constructive (1) y'know (2)

0022.32		((laugh, looks down))
0022.38 0022.39 0022.41 0022.43	R	You say you, you're not sure whether crying, for yourself is constructive I feel that (.) also you're <u>afraid</u> of crying for yourself (3)
0022.47 0022.50 0022.51 0022.52 0022.54 0022.56 0022.58 0022.59 0023.03 0023.06 0023.08	C	I maybe (.) I maybe because if I feel like crying and I don't ((shrug)) or whatever there are some things that are y'know But you see ((looks left)) thats a part of it too y'know it's a ((looks up left)) y'know and I can I I hate to keep using these things that y'know we're (.) just being so conditioned <u>not</u> to y'know from a little thing of oh y'know little little men or big boys or whatever don't <u>cry</u> and (1) and
0023.11	R	Probably a seven year old could cry
0023.13 0023.16 0023.19 0023.22 0023.23 0023.24 0023.25 0023.27 0023.29 0023.31 0023.33 0023.35 0023.37 0023.39 0023.42 0023.43 0023.45 0023.47	C	Yeah,(1)((looks down)) for sure I cried I <u>remember</u> crying but I cried alone (1) but I never let anybody see me cry (.) y'know ((smile)) (.) I wonder how many people have seen me cry ((head back, laughter in voice))) two or three in the whole world [laugh] () Its kind of interesting ((looks away)) y'know I remember living with my ex-wife, or whatever she cried all the time. She cried getting up in the morning a:nd y'know just crying, ((shrug)) for crying y'know I asked ((looks down)) her sometimes about why she cried and she just said () she just wanted to ((shaking head))) felt good. () I don't know if that was healthy or whatever but probably was a lot more healthy than than what I did.
0023.50 0023.52	R	It was better than (.) never letting anyone see you cry=
0023.53 0023.57 0024.03 0024.06 0024.08 0024.11	C	=Right (2) There's just s:o many other ways to do it y'know that I've learned (4) y'know like working hard ((laugh)) not thinking ((shrug)) about it (.) y'know, n:ot ((looks down)) thinking about it
0024.12 0024.15 0024.17 0024.19 0024.22	R	This thing that a:ll the sorrow that you feel for <u>yourself</u> and for whats happened to you and all that, em that dosen't really exist thats thats just () you're too busy to (.) have any (.) thoughts of that
0024.25	C	For sure
0024.27	R	But the sorrow is still there=
0024.29	C	=For sure ()
		SILENCE (5)
0024.33 0024.35 0024.38	C	I really don't know how to and I <u>re:ally</u> ((shaking head)) don't know how to deal with that I really don't (1) I really

0024.45 0024.47 0024.51 0024.57		don't (4)((looking down)) Y'know just really giving so much of yourself and its (3) really crazy (3) too much ((sigh. looks down, smiles)) SILENCE (7)
0025.03 0025.05	R	If you <u>did</u> cry what would some of the themes of that crying be?
		SILENCE (10)
0025.18 0025.21 0025.23 0025.24 0025.28 0025.30 0025.32 0025.39 0025.42 0025.45 0025.47 0025.49 0025.51 0025.52 0025.54 0025.58 0026.00 0026.02 0026.04 0026.08 0026.11 0026.14	C	just (.) y'know all those y'know hours that I spent away from my family and I gave up my family and didn't see my children grow (.) y'know (.) really wanted that to be for a (.) some kind of a higher level, some kind of a cause y'know (1) but not to h:ave that em (2) to <u>see</u> anything, any <u>benefit</u> that I did (.) y'know all of that work I mean <u>hours</u> and hours and (.) ((looks down, shakes head)) its just incredible and I think th:at would be one y'know I was saying dammit ((lifts hands)) why in hell did I spend so much time (.) why did I spend so much time y'know the leukaemia t:he everything that happened to me or whatever would be properly deserved if <u>one</u> person (.) life would've been changed or something y'know and like (.) and maybe it has or whatever but I think that I don't trust that its been worth it you see
0026.16 0026.17 0026.20 0026.23	R	You invested a whole lot of caring, a whole lot of yourself and, and you feel a <u>real</u> sorrow that maybe nothing came of that
0026.26 0026.28 0026.33 0026.35 0026.37 0026.40 0026.44	C	((looking down))(2) Yeah and I'd <u>also</u> like to em just kinda cry for my (.) father-in-law too ((looking away)) that was killed ((eye contact)) before I (.) about six months before I got the leukaemia. I'd like to really tell him that I (2) that I really loved him a great deal
		SILENCE (6)
0026.53 0026.55 0027.00 0027.02 0027.05	R	you're telling <u>m:e</u> in place of telling <u>him</u> (2) maybe you could even speak to him I don't know but at any rate you really would like to (.) tell him 'I <u>loved</u> you, you know that I <u>loved</u> you.'
0027.07 0027.09 0027.10 0027.13 0027.15 0027.16 0027.19 0027.21 0027.24 0027.27	C	Well I really would y'know and the the situation that we started out ((raises hands)) I was married and we married somebody of a different race ((shrugs)) and we fought it out tooth and nail or whatever but (.) we loved each other and we fished together a:nd he was great with m:e y'know he had a very, to other people a very cold way y'know of y'know (.) "by God this is the way its

0027.29 0027.31 0027.34 0027.36 0027.40 0027.41 0027.44 0027.47 0027.48 0027.50 0027.52 0027.54 0027.57 0028.00 0028.04 0028.08 0028.12 0028.14 0028.16 0028.19		going to be” and so forth but I saw him when he was hurt too a:nd em when he was killed in in 1975 in a hunting accident (.) it just really took all of it y’know ((shaking head)) because he. he <u>helped</u> me to get to try to get out of that stuff by saying ‘hey what are you doing? what do you really want to do?’ and at the time I really wanted to y’know ((smiles)) open my own restaurant or whatever (.) and so he was going to help me finance that restaurant y’know (.) and so a week later he was killed one week a:nd eh (1) and so we were getting <u>so</u> close that I re:ally never told him that, ‘hey Dad y’know hey D:ad I love you, I <u>really</u> love you.’ and we told each other I guess in some ways or whatever but its not the same as saying y’know “hey I really love you I really care’
0028.20 0028.22	R	You feel real sad that you never gave him a straight message on that (.)
0028.24	C	[For sure]
	R	[that I love you]
0028.26 0028.28	C	(.)because he was straighter with me than a lot of people
0028.29	R	mm
0028.30 0028.35 0028.38 0028.39 0028.42 0028.43 0028.46 0028.48 0028.52 0028.55 0028.57	C	y’know () and to now to be taken away from all of that (1) you see because its only been I don’t know what eight months or so since (1) ceased all communication with my family y’know family that or my wife’s family () that I’d loved and I’d cared for and then I buried my father-in-law () and that was it that was the and then even the <u>family</u> began to take on the same things that the culture y’know
0028.58	R	Things began to fall apart for
0029.00 0029.03 0029.05 0029.10 0029.13 0029.14 0029.17 0029.21 0029.25 0029.27 0029.29 0029.32	C	For sure, for sure and I don’t know (1) falling apart or at least my being able to see that that it wasn’t true, it wasn’t real, I wasn’t getting anything back I wasn’t getting anything, any nourishment y’know () Smiles and polite kisses and things like that y’know (1) that is (1) y’know part of the hurt y’know I’d rather for somebody to say y’know I think you’re a lousy SOB or whatever as opposed to saying “hello dear how are you ?” y’know, y’know?
0029.36 0029.38	R	when the real message perhaps is I think you’re a lousy SOB
0029.39	C.	Right, right y’know

Section C Case work

Reflections on clinical supervision: an analysis of the supervisory relationship with three supervisees.

1.0 Aims

The aims of this case study are

- To present an overview of three supervisory relationships
- To discuss issues arising in these case studies
- To consider these case studies in relation to models of supervision

2.0 Introduction

As a chartered counselling psychologist and educator with quite a number of years experience part of my clinical work involves supervising both novice and experienced counsellors and counselling psychologists. In recent years I have been struck by the differing ways in which I work with different supervisees and have chosen to explore this issue in some depth for this case study.

In particular I have selected three supervisees all of whom I began working with around the same time, about two years ago, and with all of whom I feel I have formed a special relationship. However, the relationship does not feel the same with each of them and I am interested in why this should be the case. In my reading I have come across a mound of literature on the topic of supervision and have found some of this useful in helping to guide my thoughts. There appear to be many views on the goals and functions of supervision and quite a few theoretical models of the supervision process within the counselling profession (Hawkins & Shohet, 1989; Carroll, 1996; Page & Woskett, 1994). However there is little which is specifically addressed to the profession of counselling psychology itself and it may be the case that supervising counselling

psychologists differs from supervising other professional therapists due to differing philosophical paradigms or practice contexts.

2.0 Models of Supervision

The starting point of most literature on supervision is the literal definition of the word itself, to oversee, implying that a supervisor has a managerial role in ‘overseeing’ the work of the supervisee. Whether this is interpreted as an assessment or judgement of the supervisee and to what extent supervisors are seen as responsible for their supervisees is a matter of debate (Carroll, 1996).

The origins of the concept of supervision clearly lie within the paradigm of apprenticeship; the idea that a trainee or novice will learn the skills of the master by being in close contact, observing the master as work, being observed by the master and receiving feedback from the master. Early concepts of supervision were based on this apprenticeship model as novice therapists were inducted into their therapeutic model by a master who was an expert in that model (Friedlander et. al, 1989; Hart, 1982; Hess, 1980). Such a hierarchical relationship does not sit well within the philosophy of counselling and psychotherapy and therefore the relationship between supervisor and supervisee is seen as much more equal and collegiate today than it was in the beginning. In the 1960s an alternative to this approach was triggered in a paper by Hogan (1964) suggesting that there were four stages to the development of the psychotherapist. This gave rise to a new set of models of supervision based on the view that supervision should be relevant to the developmental stage of the therapist.

It has been claimed that there exist between 18 and 26 different models of the supervisory process within counselling and psychotherapy (Page & Woskett, 1994; Holloway, 1995). The most influential models in British counselling and psychotherapy have much in common and there are large areas of agreement between them. In the

main the focus has been on identifying the aims, tasks and functions of supervision.

Carroll (1996) sees the purpose of supervision as being both to ensure the welfare of the client by monitoring the competence level of the therapist and secondly to enhance the professional and personal development of the therapist in order that she may move from the position of novice to that of master. Holloway's (1995) definition of the purpose of supervision does not include the notion of responsibility for the client but does fall within the apprenticeship paradigm, 'Supervision provides an opportunity for a student to capture the essence of the psychotherapeutic process as articulated and modeled by the supervisor and, subsequently, to recreate this process in an actual counselling relationship' (p.1).

A study by Fortune & Watts, (2000) comparing the ratings of supervisors and supervisees of different aspects of supervision concluded that, 'supervisors and supervisees placed significantly different levels of importance on supervision and a number of its tasks' (p.5), suggesting that there is not always agreement about the aims of supervision.

The functions of supervision were specified as formative, restorative and normative by Proctor (1986) and similarly educative, supportive and administrative by Carroll (1996).

In Holloway's (1995) systemic model these are termed monitoring/evaluating, instructing/advising, modeling, consulting and supporting/sharing. Carroll developed his generic model to include seven tasks of supervision namely, creating the learning relationship, teaching, counselling, evaluating, consulting, monitoring administrative aspects and monitoring professional ethical issues. For Holloway the tasks of supervision are to promote counselling skill, case conceptualisation, professional role, emotional awareness and self-evaluation. As models these examples have much value in guiding the work of supervisors but little research has yet been conducted into what

supervisors actually do. Clarkson and Aviram (1998) conducted a phenomenological study on the meanings of the concept ‘supervision’ from a supervisor’s perspective. The focus was not on what supervisors do or should do but rather on how they understand the concept of supervision. The supervisors were all from a humanistic/existential orientation and are referred to as supervisors of counselling and psychotherapy. The analysis showed that there were six facets describing supervision: structuring, teaching, nurturing, the ‘supervisor-as-person’, the ‘supervisor-as-colleague’, and the triangle ‘client, therapist, supervisor’. This study suggests that supervisors understanding has been influenced by the models they have read but also an awareness of the complexity of the role in relationship – something which traditional models have failed to address.

3.0 Supervisees

The three cases chosen for this study are three male therapists with whom I have been engaged in a supervisory capacity for a minimum of two years. I have met with each on either a monthly (George & Steven) or a fortnightly (Mathew) basis during this time and set up an agreed contract with each at the beginning of our relationship.

3.1 George

I had known George as a colleague for about a year before he approached me with a view to becoming his supervisor. He is an experienced counsellor (not a psychologist) and trainer, strongly committed to a person-centred orientation. His practice includes working for Relate, working as a student counsellor and seeing private clients. I felt an empathy with George and believed that we would be able to work well together. We shared a theoretical orientation and I had spent some years in student counselling services in the past which I felt gave us a shared perspective on which to base our work. My knowledge of his work and local reputation as a gifted therapist encouraged me to

agree to be his supervisor.

3.2 Steven

Like George, Steven is an experienced counsellor of many years standing but our initial relationship began when he registered to train as a counselling psychologist on the course with which I am involved. As it is not the course policy to provide supervision for trainees our supervisory relationship did not begin until Steven had completed his training some years later and was searching for a supervisor who has a counselling psychologist. Steven works with a specialised group of clients who suffer from hearing impairment and although this was an area of which I had little experience I felt enthusiastic about supervising work in a novel area where I too could learn something. Again, as with George, Steven is strongly committed to a person-centred therapeutic model and I felt very comfortable and confident in agreeing to take on the role of his supervisor.

3.3 Mathew

My third case in this particular study is Mathew who is currently training as a counselling psychologist via the British Psychological Society's Diploma in Counselling Psychology. I had not met Mathew prior to his initial contact inquiring if I would be in a position to consider supervising his practise work and suggested meeting up to discuss the matter before we committed ourselves. Mathew was very nervous on this first meeting and I felt that he was desperately in need of support and guidance for the work that he was doing in a voluntary organisation with quite a complex case load. I was aware of being positioned in the role of the expert from the beginning and felt almost overwhelmed by the need to rescue this man who was disappearing under a huge amount of responsibility and work with very little experience to draw upon. In addition to these concerns, Mathew worked within a cognitive-behavioural approach which is

very different from my own person-centred preference and I had doubts about being able to offer him adequate support within his chosen model. Thus, although my initial response was to turn down his request for supervision outright I had liked Mathew very much and had been touched by his conscientious enthusiasm in the face of much adversity, so agreed to try a six week trial period.

These three cases, therefore, came to me in different ways with differing experiences and expectations, two I knew quite well, one I did not; two worked within my theoretical orientation one did not; two had a background in psychology, one did not; two were experienced therapists and one was a novice. They had in common their gender (male) and their age (mid-forties).

4.0 Supervisor

In my role as supervisor I perceive myself to be an experienced therapist, a qualified psychologist and a supportive facilitator. My adherence to the person-centred approach permeates my supervisory work as well as my work with clients and I focus my attention on relationship and process issues. My aims within this model are to facilitate the development of the supervisee by providing a nurturing environment based on the core conditions of empathy, unconditional positive regard and genuineness (Rogers, 1951). Within this environment supervisees are able to explore their own beliefs, values and practice without fear of judgement. Research has suggested that theoretical orientation is an important determinant of supervisory behaviour (Carroll, 1996; Holloway, 1995) and although I am aware of the many functions of supervision (Carroll, 1996, Holloway, 1995; Page & Woskett, 1994) my aim is to facilitate supervisees to become aware of themselves in relation to their clients, primarily and be present in both the therapeutic and supervisory relationships. In order to apply this

model in supervision I use the skills which enable me to enter the world of the supervisee, to identify blocks to their awareness and facilitate them to address these issues in terms of their own personal development. A person-centred approach equates learning with personal development and although a supervisor must sometimes play the role of an educator I strive to fulfil this task by encouraging the supervisee to become aware of the gaps in their knowledge or skill base and consider how they may address these issues for themselves. The model of change which I apply to my supervision work is based on the goals of an increase in self-awareness and an achievement of the supervisee's potential. For each supervisee this potential will be different and their own individual goals must be defined in the early stages of supervision. As a counselling psychologist I believe that I also offer a framework from which supervisees can construct relevant frames of reference for their work. The foundations of this framework lie in the reflective scientist-practitioner paradigm and the importance of a research base for practice is an abiding theme in all my work with supervisees.

5.0 Overview of work with each supervisee

5.1 George

George arrives for supervision, always on time and carrying a file of case notes. He has detailed notes on all clients and maintains a meticulous casework and supervision log. George is already a very self aware and personally integrated therapist and his goals for supervision revolve around maintaining ethical practice and sharing his client experiences in a mutually supportive environment. Our sessions follow a standard format of working through the four or five clients that appear, with summaries of the sessions, on George's log, of which I keep a copy. George presents his clients in a descriptive manner, telling the story of the session in the way that he remembers it. Occasionally he will stop and flag up queries that he has for me which may then lead

to a discussion of a particular issue. He will explain his theories and hunches about what may be happening for his clients and indicate the reasons why he adopts a particular strategy as opposed to another. In the main I listen carefully to the narrative attempting to move into the client's world but also be aware of the way that this world has already been interpreted by the narrator. I form tentative hypotheses about the client and check them with George's, when they do not coincide I offer my ideas as food for thought. I am feeling my way carefully between the client's world, George's world and the relationship between the two. Often, I am humbled by the power of George's empathy and understanding of his clients and his ability to build a trusting therapeutic relationship. However, I am also aware that George becomes blocked in his work with some clients as a result of missing some of the more intricate process issues within the therapeutic relationship and has a tendency to shy away from confrontation. George regularly brought a particular client to supervision over a period of months and was becoming increasingly frustrated with this client's failure to engage with the therapy in a meaningful manner. The client was well versed in therapeutic jargon and the therapy sessions involved interactions which appeared on the surface to be therapeutic. However, each time that the client returned she reverted to a description of her problems as though she was still in the initial phases of the relationship and had failed to gain any insight into her situation. George's approach had been to focus on empathically listening to the client and accepting her as an individual in order to build her self esteem and gradually facilitate her search for meaning in her life. I was able to sense the frustration that George was feeling beginning to turn to self-doubt and was aware that he was starting to dread his sessions with this client. In order to help George get in touch with himself and his feelings about this client I confronted him by asking him to talk genuinely about his feelings toward the client. He was able, slowly, to accept his own feelings of frustration and impatience with the client and rather than see this as a

failure on his part we were able to work on making sense of the relationship itself. I was aware of the need to provide a non-judgemental space to facilitate George in this exploration of his negative feelings towards clients and to allow him to accept that these feelings are valuable therapeutic material which can lead to both insights into oneself and into the client's world. This work resulted in George being able to confront his client and tell her how he was feeling which in turn resulted in a break in the pattern of therapy and a moving forward for the client.

George is aware of his own personal weak spots resulting from a difficult childhood with an alcoholic father, his own failed marriage and the death of one of his own children but he provides himself with as much support as possible through personal therapy and the support of a religious community. When a client triggers any of these sorrows I am now able to spot it in the small changes to George's expression and we are able to check that he feels able to continue working with the client.

When I first began working with George I was struck by his lack of a systematic assessment and formulation of his client and was initially concerned about the apparent lack of structure in his conceptualisation of the client problem. I began to check out with him his understanding of his client and realised that he was sticking very closely to his intuitions and feelings and was able to provide a clear summary of where the client was at that moment which he was able to communicate to the client and thereby move the relationship into a deeper phase. I realise that had George been a novice therapist I would have insisted on a clear assessment and formulation for each client and encouraged a much more structured approach to the therapy but working with George has convinced me that, as with most skilled behaviour, once one has become experienced the separate steps become imperceptible and the process becomes seamless.

As a counsellor, rather than a psychologist, George's knowledge of research literature is less than I would expect from a counselling psychologist and George has found my sharing of more scientific knowledge with him to be beneficial and informative. In this way, although the educative aspect of supervision may generally diminish as the supervisee's experience increases, it may be the case that cross-professional supervision may prolong this stage as information is shared and new ideas explored.

5.2 Steven

Supervision sessions with Steven feel a lot more collegiate than those with George.

Although Steven also keeps detailed case notes on all his clients these do not form the basis of the sessions but are used to refresh his memory when necessary. Often we will spend the whole session on just one client and particular clients have been the focus of supervision over a number of sessions. Rather than describing his client sessions in detail Steven's approach is theme based. He will bring a particular issue that has arisen with a client and we will discuss this both in relation to that particular client but also in relation to other clients and in a more abstract manner, in relation to general professional and personal issues. These discussions often become theoretical and we indulge ourselves in sharing our views and experience, often incorporating our knowledge of published literature and recent research findings. Steven, like George, is an experienced therapist and his supervisory needs include monitoring his work with clients, exploring his own strengths and limitations and support for his evolving professional and personal needs. As a result of his recent training in counselling psychology Steven has started to explore the way in which he works with clients in a more psychological manner. He has incorporated a more cognitive approach into his basically person-centred practice and we have discussed issues around the benefits of integration but also the difficulties in moving between models. His increased theoretical

knowledge has provided him with resources which were not there before and he has become particularly interested in psychodynamic ways of working. Although this is not a model that I use in my own client work it has been useful to explore with Steven the additional insights which this approach offers in relation to his client work and to consider the effects of this on his personal development.

Steven is an intelligent, self-aware and reflexive practitioner. His insights into therapeutic process demonstrate his skill and experience. As a supervisor I have only occasionally brought to his attention aspects of his relationship with clients that he had not yet become aware and I felt were affecting his client work. During a period of personal difficulty for Steven I became aware of the affect that this was having on his clients and was able to advise a period of rest which was accepted almost with relief. Steven, like George, has a tendency to resist terminating therapy with clients who are not progressing. He feels as though this is 'giving up on them' and that he must continue even if there are little signs of development. Our supervision focused on a particular client exclusively over a number of sessions. She had been referred to Steven because she had experienced a deterioration in her hearing and was suffering psychological problems as a result. As this was a fairly typical referral for Steven he approached the work with her in a person-centred manner, focusing on establishing a therapeutic relationship and providing a nurturing environment within which the client could begin to explore her issues. However, it became apparent that the client was unable to take responsibility in any way for her own psychological health. She believed all her problems to stem from external events and people in her life. She saw herself as a victim and resisted all Steven's attempts to provide a different view of the situation. As I listened to the accounts of this client (including some audio-taped sessions) I became more convinced that she had a controlling personality and that Steven, like all

the men in her life, had been swept into this complex world which she had created for herself, and positioned as another persecutor. Steven, however, was resistant to my reading of the situation and was unhappy with the notion that processes were occurring of which he was unaware. I felt that our own relationship was becoming jeopardised by his relationship with this client, it was becoming a parallel process in which Steven was beginning to see himself as the victim and myself as a persecutor. My views that the client may be manipulative were seen by Steven as a lack of empathy on my part. I felt that Steven was losing touch with his own world and being drawn deeper in to the world of the client where he was no longer offering her therapy but feeding her own destructive needs. It was difficult at this time to stick within the person-centred model and I felt tempted to advise Steven to terminate with the client immediately. However, I was also aware that this would be further evidence of my persecutory qualities and would not provide Steven the opportunity to gain insight into this situation for himself and therefore develop his professional work. Instead I decided to model a more challenging approach by spending a number of sessions looking at the relationship between Steven and myself and encouraging an open and honest discussion of our frustrations and fantasies about each other. My aim was to restore the foundations of our relationship, to allow Steven to feel safe again and to provide a model for the approach that he could then take with his client. Although painful the approach was successful and we were able to move onto addressing the issues in his work with this client from a firmer base. Ultimately the client herself terminated the therapy in a particularly messy and destructive manner and Steven began to retrospectively address issues regarding his work with this client.

My relationship with Steven has felt very equal. I have learned much from him and I have felt that I provide him with a sounding board for his client work and an

opportunity to explore his thoughts and feelings in a safe environment. I look forward to sessions with Steven and always feel that he has left me with something precious at the end.

5.3 Mathew

Unlike George and Steven, Mathew is a relatively inexperienced therapist. He has recently begun his training as a counselling psychologist and much of his knowledge has come from personal reading rather than client work. However, at the start of our relationship Mathew had two placements where he was seeing quite a large number of clients, some with quite complex histories and presenting problems. Mathew was firmly established within a cognitive-behavioural paradigm and he impressed me with his theoretical knowledge of this approach. At the start of our relationship I made it clear to Mathew that I was not a cognitive-behavioural therapist and that he may find it confusing to have a supervisor from a different paradigm. While appreciating my concerns, Mathew wanted to give it a try and we agreed to work together for six sessions and then review.

Mathew turned up for supervision with hand written notes on all his clients which were much less formal than those that most of my supervisees brought. As he worked in organisations which did not have formal systems for keeping case notes he was unaware of the norms around this procedure. This was one of the many administrative tasks that I explored with Mathew and I felt very much that his supervisory needs included guidance on general systems or organisation as well as client work itself. An enduring theme in our early work together was that of boundaries. As Mathew was the only therapist in one of the organisations in which he worked, there were no systems or norms to offer a framework for his practise. He would have to establish these for himself. As is often the case with novice therapists Mathew felt a need to own his

client's problems and be overly responsible for them. As a result he had made himself available to clients outside of office hours and allowed them to contact him at home. I voiced my concern over this and we discussed the issue of boundaries and self-care at length. It took some time and quite a lot of agonising for Mathew to begin to set up boundaries around himself and to understand how these are essential if we are to give our best to our clients. With one particular case a very disturbed client would continually resist the ending of the session and actually refuse to leave the building. The way in which Mathew had resolved this was by agreeing to the client's request for a lift home. Thus, a pattern had become established whereby after the session (which was the final one in the evening) Mathew would drive the client back to his home. The issue for Mathew was a pragmatic one, he felt that this option at least achieved the goal of getting the client out of the building and he had felt that the client was extremely fragile and required 'looking after'. My initial reaction to this story was to forbid Mathew from continuing with this behaviour and express my real concerns over the many implications of such a strategy. However, I also was aware of Mathew's need for support and nurturing from our relationship. My task was to maintain the supervisory relationship in order to sustain Mathew's self confidence and encourage his development but also to prevent him from behaving unethically and putting himself or his client at risk. By using our own relationship as an example we began to explore the issue of boundaries and their importance. We then gradually moved on to looking at Mathew's relationship with this client and issues around dependency and collusion. This involved quite a lot of self exploration and was a challenging process for Mathew, involving thinking about the difference between therapy and practical caring, the need to make clear boundaries around his role in the organisation and issues around working safely with clients.

I felt an anxiety in my early work with Mathew over his lack of experience and my own responsibility in having to fill in the many gaps that existed in his practical knowledge. His understanding of process issues was limited and, working within a CBT approach this was not something that he had addressed in his reading or been attuned to in his case work. I understood my anxiety to be partly coming from Mathew himself but also from the role of teacher and expert in which I had been cast. There was some parallel process occurring here as he presented himself to clients very much as an expert offering them a treatment. However, I persevered with my efforts to focus our sessions on process and to build his confidence in being himself rather than hiding behind a role. We used role-plays to allow him to practise different approaches with clients and we talked about the process within our own relationship as an example. I felt that Mathew needed more support from supervision than many trainees because he had so little support in his placement organisations. However, as time progressed and Mathew enrolled for a training course things began to click into place. He took the initiative in setting up systems in his workplace which would respect his own boundaries, he began to adopt a more reflexive approach to his client work, his notes became more formal and he began to relax into supervision. During our trial period I had begun to see a lot of potential in this supervisee, he had moved a long way in a short period of time and was beginning to have successful outcomes in his client work. I was impressed with his enthusiasm and commitment to his work and felt that he had really begun his journey. We agreed to extend his contract and now, a year later, Mathew has completed the first part of his training and has developed into a competent and skilled practitioner.

6.0 Discussion

In considering the three cases presented above I am struck by the differences in the ways that I have worked with each supervisee but also aware of having consistently

stayed within my own particular style and frame of reference. There is research evidence that supervisors interact differently with different trainees, implying that there is an attempt to accommodate the natural style of the supervisee in the supervision process (Holloway and Wolleat, 1981). It has also been suggested that supervisors are aware of adapting their teaching style to individual trainees (Fortune and Watts, 2000). I felt most natural in my work with Steven as we shared a common philosophy and focused most of our work on process issues which sits well with my therapeutic approach. Although George and I also shared the philosophy of our therapeutic model I felt myself pushing him to link his practice more with the research literature and follow up ideas through reading. This reflects our different professional backgrounds and my roots in the scientist-practitioner model. With Mathew I felt most challenged as the boundary between my role as trainer and as supervisor was often blurred. My style of working in this case was much more educative than would be normal for me as a supervisor and I often felt uncomfortable with the inequality in the relationship between us. I was also more keenly aware than normal of my responsibility toward Mathew's clients. As a novice therapist he needed to check with me that he was 'doing the right thing' and I needed to be sure that he was not putting himself or clients at risk. There was an added boundary complication in this relationship in that as Mathew's designated supervisor I was required to complete an assessment report on his practise work as part of his overall assessment on his training course. Although in the past it has been argued that the functions of evaluation and education should be separated and it was not beneficial for clinical supervisors to play an assessment role, more recently the opposite view has been advanced. It is now considered that as supervisors are continually monitoring and evaluating their supervisees as part of their educative role they are in fact the best people to make an assessment (Bernard and Goodyear, 1992; Mueller & Kell, 1972). Although I felt able to comment on Mathew's developing skill,

competence and insight I also was aware that he was striving to present himself as a competent therapist and may not have felt able to share with me his worries about his inadequacies.

With all three supervisees I have worked predominantly at the level of relationship as it is my core belief that therapeutic change depends on relationship and the skill of the therapist in developing and maintaining a therapeutic relationship independent of his therapeutic model or type of intervention strategy. The supervisory relationship is at the core of Holloways's systemic model of supervision and as with the therapeutic relationship itself is considered critical to success (Holloway, 1995). It is important in the development of this relationship that supervisee and supervisor agree on the nature of the relationship and its functions and goals but some studies have suggested that this agreement is not always there (Worthington & Roehlke, 1979). Supervisees may engage in supervision without being fully aware of their own supervisory needs and it is a common finding that novice supervisors prioritise the learning of new skills over other aspects of supervision more highly valued by supervisors such as the giving of feedback (Worthington & Roehlke, 1979; Reising & Daniels, 1983). I felt this to be the case in my work with Mathew who was focused, at the beginning, on finding the appropriate intervention more than on establishing a relationship with the client and allowing time to listen to the client's story. I had a recurrent feeling of having to rein him in and slow him down in order for him to reflect slowly on the process itself before making a decision about how to intervene. This contrasted sharply with my more experienced supervisees who rarely asked for demonstration of new skills or advice on which intervention to use. Clearly they had a vast 'tool box' at their disposal and, as skilled practitioners, were able to respond almost automatically to clients without being aware of the decision making process itself. However, there are disadvantages too in being a

skilled practitioner. On a few occasions with both George and Steven I could see that they had made inappropriate assumptions about clients which led to inappropriate interventions and until I asked them to work through the situation slowly they were unaware of the mistakes they had made. This highlights the importance of supervision for experienced practitioners as well as trainees and the need for constant vigilance against complacency.

Developmental models of supervision suggesting that the needs of supervisees change with experience were triggered by Hogan's paper on the four stages in the development of a psychotherapist (Hogan, 1964; Worthington, 1987; Stoltenberg & Delworth, 1988). If the therapist moves through a number of developmental stages then to be effective, supervision should be appropriate to the relevant stage. The concept of development focused around growing competence and awareness and it was thought that supervision should focus on the changes in competency in therapeutic skills, conceptualisation of the therapeutic process, personal and professional development and awareness of the dynamics of the therapeutic relationship. For example Stoltenberg & Delworth (1987) present a four stage developmental model of supervision where the trainee at level 1 is motivated, anxious and dependent, at level 2 is moving toward autonomy and independence and has fluctuations in motivation. At level 3 has an increased sense of personal identity, more stable motivation and increasing creativity and flexibility. The final stage is where the therapist becomes a fully functioning practitioner or master and it is noted that this stage may not be reached by all. The supervision focus also develops in line with the evolution of the therapist offering more support and structure at the beginning and moving through containment and onto more collegial support and finally reaches a stage of mutual consultation. Research on developmental models offers some support to this concept but suggest

that the process is much more complex than it would appear from the model.

When considering the relevance of this model to the case studies presented here I am aware that Steven and George would fall into level three on Stoltenberg and Delworth's model as they both had a strong sense of personal identity and clear motivation in their work but were also able to be flexible and creative where necessary. Mathew began in level one and has now progressed into level 2 as his confidence has increased and he is beginning to develop his own independent identity. However, as Steven has evolved from a counsellor into a counselling psychologist I am aware that he lost some of his previous autonomy and became much more questioning of his work. Perhaps in part he had to revisit some of the earlier stages of development. One of the criticisms of developmental models is the notion of an end point that signifies the completion of development. In my experience of supervision this end point does not exist. We are always developing in some way and, as with Steven, there are times when we choose to develop ourselves some more or in a different direction. The very notion of professional development would suggest that this is the expectation for any professional person. Therefore, models of supervision should incorporate the concept of constant evolution if they are to be useful frameworks to guide our practice.

Although the research suggests advantages and disadvantages in matching theoretical orientation in supervision (Proctor, 1994; Hawkins & Shohet, 1989) and the apprenticeship concept of supervision demands that matching is essential, my experience of working both within my model and outside of my model within the cases presented here has given me cause to reflect on these issues. It certainly felt easier and more relaxed to work within a person-centred paradigm with George and Steven than to attempt to share the cognitive-behavioural model with Mathew. However there was something challenging for me in moving outside my comfortable niche and consider

a different way of working with clients. At times I felt that Mathew was hampered by his symptom focused approach and was missing aspects of the broader client's world which would have been the focus of my work with such a client. However, I also began to enjoy the clarity and focused nature of Mathew's way of working, especially when symptom relief did occur fairly rapidly for some clients. In my work with Steven I also moved out of my person-centred mould to accompany him on his journey through a number of alternative approaches including cognitive-behavioural, psycho-dynamic and existential. I felt that I too learned something from considering the benefits of other techniques and philosophies and greatly enjoyed the more philosophical debates we had around these issues.

There are many approaches to the supervision process and I feel that the approach that I have presented here fits well within the person-centred orientation and also the professional context of counselling psychology. There are many tensions within a supervisory relationship and a need to balance competing demands and goals. The benefit of staying close to the core element of relationship I think is fundamental. In dealing with difficult issues in supervision, I have always tended to revert back to my relationship with my supervisee. This has often acted as a model for the issues raised in the therapeutic relationship and has usually provided a stable base to enable the supervisee to take risks and explore difficult material in a non-threatening manner. My struggles within supervision have been to do with being projected into a role that I was uncomfortable with by my supervisee. I have learned (or perhaps relearned) the value of explicit contracts, of reviewing, of checking expectations and not making assumptions. These therapeutic skills are equally important in supervision. It has been valuable on occasion to refer back to agreements that were made at the beginning of supervision, to assess where we have been and where we are going. This both provides a model for the

supervisee which can be applied in their therapeutic work and encourages a constant reflection on the process itself. The dual role of supervisor and assessor is still one that I find difficult as do many others and as yet have not resolved. I feel that the success of my approach is born out by my long term supervisees who have been with me for a number of years. I am alert to the evils of complacency and try to avoid allowing our relationships to become too ‘cosy’ but I am still encouraged by the continuing development of my supervisees and the amount of learning at many different levels that takes place in supervision.

7.0 Reflections

The importance of reflexivity cannot be over-estimated and I work with all supervisees to encourage continual reflection on their practise, their clients and themselves. I bring my supervisees as well as my clients to my discussions with my own supervisor and benefit greatly from reflecting with her on the similarities and differences between therapy and supervision. This exercise itself has been illuminating in bringing to my awareness issues which I had casually swept away in the business of a professional life. From all three supervisees I am aware that I benefit from their respect of my professional position and expertise but also my individual style and beliefs. This is rewarding and enhancing to me as an individual. I hope that I pass on qualities which I value to my supervisees through my knowledge and way of being that they will be able to incorporate into their own work and enhance the practice of counselling psychology in the future.

I have also benefited greatly from the clients themselves whose lives I have briefly entered into through the accounts of my supervisees. Some of these stories have touched me deeply, some have caused me worry and concern and many have finally brought me

joy when resolutions have been found and distress alleviated. I worry about my responsibility to clients when I must ‘oversee’ their therapy at arms length and I struggle always to find a balance between trusting my supervisee’s insight and competence and intervening to check that all options have been considered and risks have been reduced to a minimum. As with clients, supervisees must develop and grow at their own pace and in their own direction and I see my role as a supervisor as providing the safest environment possible in which to do so. The satisfaction of being a supervisor (also a teacher and a therapist) is in watching people develop and grow.

8.0 Conclusion

Supervision, in recent years has become not only a compulsory part of most counselling and psychotherapy training but also a compulsory part of professional practice. Its value must therefore be considered to be great in maintaining competent and ethical practice. There is also a steady growth in training courses in supervision and rumours that compulsory training may be introduced for supervisors in some professions. As discussed at the beginning of this case study, there are many models of supervision practice but as yet a limited body of research evidence around the evaluation of these models or their relevance to particular professional groups. As scientist-practitioners this may be an area of research that counselling psychologists could engage in and also consider a model of supervision that may be particularly relevant to our profession.

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Section D Critical Review of the Literature

Ethical Issues in interview based qualitative research in counselling psychology

1.0 Aims

This literature review aims to examine the status of interview based qualitative research within counselling psychology and the ethical and moral questions arising from the growth of this technique. The general focus of the review is the interviewing process as a means of collecting data and the nature of the relationship between the interviewer and interviewee. In the main the type of material reviewed falls within the frame of phenomenological research.

Within this broad aim the review will address the following themes:

- The overlap between therapeutic and research interviews
- The relevance of ethical codes to qualitative interviews
- The scientific value of the qualitative interview in counselling psychology research

2.0 Introduction

Research in counselling psychology may still be in its infancy but the issues raised in relation to carrying out research on vulnerable human participants are shared with other more established therapeutic professions such as counselling and psychotherapy and with psychologists in related fields such as clinical and health psychology.

The increase in the use of interview based qualitative methodologies and more narrative based approaches within social science research has provided a means to explore the therapeutic process in depth in a way which creates a qualitative difference in research

design and analysis from a more traditional experimental model (McCracken, 1988). The focus in phenomenologically based interviewing is not on measuring the reactions of the research participant to various interventions of the researcher but instead on recording and understanding something of the participants' experience which is facilitated through the development of a trusting relationship. This difference raises a number of specific ethical and moral issues which arise from the differences between the nature and philosophy of the therapeutic and research relationships. As researchers become closer to their participants through research techniques such as qualitative interviewing (Mason, 1996) both participant and researcher become more vulnerable. The aims of counselling interviews are therapeutic, the aims of research interviews are scientific and each are bound by a particular but different set of rules and norms. However, in practice, the two appear very similar. When a counselling psychologist adopts the role of both researcher and therapist they are attempting to straddle two different paradigms. The importance of the concept of research – based practice is fundamental to the profession of counselling psychology and recruits to the profession are trained in research methods in order to equip them to become researchers as well as therapists. However, this distinction is in danger of becoming unclear, or even for some commentators, unnecessary (Coyle, 1996).

My argument in this review is that the more we allow the therapeutic relationship to overlap with the research relationship the greater the potential for harm to all parties involved. Professional ethical codes protect clients and therapists and also researchers and participants but they will only be effective within their own frame of reference. In other words while 'doing research' ethical codes governing research are effective; while 'doing therapy' codes of practice are effective but when the research interview starts to resemble a therapeutic session then neither code of ethics can apply because there is a

conflation of paradigms. When a researcher starts to behave as a therapist she is no longer conforming to the role which is governed by research ethics and vice versa. It is my view that by inhabiting a place that falls between two sets of ethical codes we then fall back on professional and personal notions of morality. The literature reviewed here suggests that existing ethical codes relating to research do not provide an appropriate framework for research based on qualitative interviewing techniques because the ethical issues raised by such techniques are to do with notions of moral agency within relationship rather than protection of participants, ‘an interview inquiry is a moral enterprise’ (Kvale, 1996:109). The issue, I believe, is not the short-comings of ethical codes but rather the confusion between ethics and morality resulting from a conflation of paradigms, ‘...the notion of ethics is so hazardous and ineffective in the context of social research that thought should be given to establishing a professional morality’ (Homan, 1991: 2).

I intend to present my argument through a review of the literature on the overlap between research and therapy, the literature on ethical guidelines and to conclude with a consideration of the way forward for counselling psychology research.

3.0 The relationship between research and therapy

The therapeutic relationship and the research interview on the surface appear to have something in common. In both there is a telling of experiences by one participant while the other listens with a view to making sense, interpreting, re-framing and understanding the narrative. In fact if one were to eavesdrop on such an interaction could one tell the difference between a therapy session and a research interview? In a qualitative analysis of meaningful moments in couples therapy it was found that the research interviews themselves were reported to have greater therapeutic impact than

the therapy (Gale, 1993). Many commentators present the view that the advantage of the qualitative interview is that it allows the researcher to get closer to the participant and thereby enhance the quality (and quantity?) of the data collected.

McCracken (1988) claims that the qualitative interview gives the researcher the opportunity, "to step into the mind of another person, to see and experience the world as they do themselves" (p.9). He sees it as essential that the participant is facilitated to 'tell his/her own story' in their own terms by the use of prompts so that the story is told in as unobtrusive and non-directive a way as possible. The assumption being that the researcher will get as close as possible to the participant's 'reality'. McCracken suggests that the qualitative interview gives the participant the opportunity to '...make the self the centre of another's attention, to state a case that is otherwise unheard, to engage in an intellectually challenging process of self scrutiny and even to experience a kind of catharsis' (p.28). One could be forgiven for assuming the writer is referring to a therapeutic encounter.

Much of the literature relating qualitative research and counselling psychology tends to take the view that the therapeutic skills of the counselling psychologist are ones that could be useful to the qualitative researcher (Gupta, 1998; Coyle and Wright, 1996; King, 1996). Gupta (1988) claims that the 'counselling style' interview is an appropriate model for research interviews as the aims of both are similar, namely to 'uncover an individual's psychological narrative' (p.13). She proposes that there are three core elements of counselling training that are relevant to the qualitative researcher, namely; knowledge of different theoretical models, training in counselling psychology skills and self awareness.

Coyle (1998) illustrates how the basic Rogerian skills of relationship building can be

successfully employed in research interviews and presents data indicating the benefit of such techniques to the participants. However there is no mention in the paper of any of the ethical dilemmas involved in giving researchers a little bit of counselling training and then assuming that they are prepared for anything that may occur in the research interview as a result of their in-depth interviewing skills. Coyle proposes that only basic counselling skills are required by researchers in this context,

‘Generally, it is sufficient for the researcher to have proficiency and confidence in using basic counselling skills and in fostering counselling attributes, together with an ability to confront strong emotional reactions’ (Coyle 1998:70).

The confronting of strong emotional reactions indicates that the research interview is expected to elicit difficult material from participants and that the researcher will be better equipped to deal with this by having picked up some basic counselling skills.

This view can be criticised on a number of levels. First, that basic counselling skills are likely to enable untrained, unsupervised and inexperienced individuals to deal with strong emotional reactions. Secondly, the ethics of proceeding with a research design which is expected to lead to strong emotional reactions and thirdly, the dissolving of the boundary between the role of research and therapy and therefore the confusion of the aims of two very different interviews.

Although he concludes his paper with a section on practical and ethical issues Coyle takes the view that if participants are aware of the difference between the research interview and the therapeutic interview (in terms of confidentiality guarantees mainly) there will be few ethical dilemmas. This seems an inappropriate conclusion to draw from a paper which has argued throughout for the benefits of ignoring the differences between the two types of interview.

Rennie (1994) makes the case that qualitative research may be, 'a better way of closing the gap between research and practice in counselling psychology than has been provided by the natural science approach to the discipline established in the Boulder model of the scientist-practitioner' (p.235). He draws out the parallels in terms of three themes, subjectivity and understanding, collaboration and empowerment, and holism.

First, in consideration of the notions of subjectivity and understanding Rennie argues that both researcher and therapists regard understanding as a valuable objective for the relationship between themselves and their clients or participants. Within the development or negotiation of such understanding, the part played by the therapist or researcher's own personality is acknowledged. As Kvale (1996) states, 'The research interviewer uses him-or herself as a research instrument, drawing upon an implicit bodily and emotional mode of knowing that allows a privileged access to the subject's lived world' (p. 125). This reflexivity is a crucial element of certain paradigms within the qualitative research area, particularly phenomenology and grounded theory modes of inquiry. In explaining the commitment of feminist standpoint research to personal reflexivity Doherty (1994) states, 'This entails a recognition of and an attempt to explicate how the researcher's identity, interests and values may be expressed in the process of research' (p. 4). This raises issues about the interpretation of the data collected from the interview. To what extent can it be seen to be the representation of the interview's situation and to what extent that of a construction between the interviewer and the interviewee? She even goes on to address the thorny issue of power, 'A crucial aspect of reflexive research practice is an analysis of and an attempt to dissolve the power differentials which exist between the researcher and the researched' (ibid., p. 4). However, with the dissolution of power differentials and therefore roles and boundaries just what is left to structure this new research relationship? In therapy a

contract is drawn up with the client in the initial session to clarify just where the boundaries are and to confront any unrealistic expectations before the therapist and client venture forth on the therapeutic journey. No such safeguards seem to exist within the qualitative research relationship.

Secondly, Rennie regards therapy derived from the humanistic tradition as promoting client empowerment and a significant method for facilitating this is to work collaboratively with the client. Within the more open-ended, explorative orientation of much qualitative work, action research for example, researcher-participant collaboration is also promoted at all stages of the research project. It is this collaborative, flexible, open-ended ethos that Rennie regards as having therapeutic potential as it can facilitate insight and enlightenment. Gale's research mentioned earlier on clients' perceptions of meaningful moments in couples therapy using the Interpersonal Process Recall method found that participants actually reported that the research interview was more therapeutic than the therapy sessions being studied (Gale, 1993). As with Rennie, Gale equated the therapeutic impact of the research interviews as deriving from the research relationship, its context, and the methods used by the interviewer to clarify his understanding of the participant's perspective. Thus, the relationship was felt to be collaborative with the aim of facilitating understanding. The context enabled the participants to develop 'multiple descriptions of their stories' and the interventions of the researcher took the form of re-framing or developing analogies to clarify and check out the researcher's understanding of the participant's story. However, 'understanding' does not mean the same thing for the participant and the researcher. The participant's aim is to understand themselves and the researcher's aim is to produce the participant's story within a scientific discourse in order to further scientific progress. If the aims differ it is difficult to see how collaboration can exist. The participant and

researcher are working toward different ends.

Finally, Rennie contends that the therapist and the qualitative researcher share a holistic approach in that both are concerned with the entirety of the individual's experience rather than simply a part. The question here is where are the boundaries? In therapy the initial contract defines limits to the enterprise, e.g. the BAC Code of Ethics and Practice states,

‘Counsellors are responsible for communicating the terms on which counselling is being offered, including availability, the degree of confidentiality offered’ (BAC 1992b). In research there is also a negotiated contract usually emphasising that the participant is free to withdraw at any time. However, Rennie’s holistic argument suggests that anything goes.

There appear to be two major ethical issues arising from the literature presenting the qualitative interview as a beneficial tool in research which are not addressed within this literature. The first relate to the lack of clear boundaries around the nature of the relationship between researcher and participant and the second relates to the assumption that the qualitative interview is a means to access ‘lived experience’ in an objective way and therefore is a positive development in research methodology. I shall explore each of these in turn.

The erosion of boundaries within a research relationship may cause distress to the researcher who is now unable to hide behind the anonymity of the researcher role and the research protocol of more mainstream research designs. La Rossa et. al. (1981) note that researchers conducting qualitative family research are often perceived as therapists and the participants often feel as though they are in therapy. For example Bott (1971) notes how she had to abandon the original unstructured interview procedure in favour

of a more structured format due to the role confusion experienced by both researchers and participants. Once the researchers began to act like researchers – asking direct questions and taking notes - a sense of relief was experienced by all.

Personal discussions with researchers working in a qualitative way have revealed that often they are disturbed by the revelations made by interviewees during their research interviews. Bathelor and Briggs, (1994) make this point in their discussion of ethical dilemmas for social and medical researchers, ‘In our experience.. .few if any social researchers will have had adequate training about the interactional aspects of their work. As a result they are unprepared for the ethical dilemmas and conflict of loyalties which they might experience’ (p.949). For example disclosure of childhood sexual abuse is rarely part of the researchers' expectations when conducting interviews into a completely unrelated topic. Yet when such things occur a researcher is ill equipped to deal with the intense emotional reaction accompanying the disclosure and the interview may end with both participant and researcher in a state of distress with little idea of where to go next. Etherington, (1996) describes the almost traumatic degree of stress experienced whilst carrying out the research on the male survivors, ‘...intrusive dreams and images left over from the painful stories I heard day after day, anxieties about responsibility, my inability to share the material with colleagues, friends and family because of the nature of the work...’(p.345). The erosion of boundaries may also cause distress for the participant. Researchers have become aware that they have established a relationship with their interviewees which renders the respondent vulnerable and the researcher responsible, "I have also emerged from interviews with the feeling that my interviewees need to know how to protect themselves from people like me" (Finch 1993:173). As Taraborelli wrote of her study of informal carers, ‘Given the subject matter, it is understandable that at times some of the interviews proved quite stressful

for both myself and the interviewee. It was not unusual for respondents to cry...' (quoted in Bathelor and Briggs 1994:179).

The second ethical issue arising from this literature results from a failure to recognise the implications of conflating the therapeutic and research paradigms. From a narrative perspective there is a view that meaning is created during the therapeutic interview, 'change is the evolution of new meaning through dialogue' (Anderson & Goolishian, 1988: 372). In other words the client and therapist exist within a dynamic whereby they mutually influence each other. Interviews do not merely elicit information they change people. If such were the case in a research interview then the notion that a researcher is objectively recording the client's story without influencing the content, tone or meaning of the story is naïve. If interviews change people then there is a case for considering the ethical implications of their use as a research methodology. If interviews change people then what is being studied – the participant as she was before, during or after the interview? It is often accepted that a transcription of a research interview is the first stage of the analysis as it represents a transformation of the data through the process of decision making about what is relevant or not, whether contextual cues and non-verbal communications are included and so forth. (Mischler, 1992). However a co-construction of the participant's story may be taking place between the interviewer and the interviewee throughout the interview.

Although the objective of both therapy and phenomenologically based research interviews may be to 'uncover an individual's psychological narrative' (Gupta, 1998) the aims are very different. In a therapeutic interview the aim is to facilitate change within the client whereas in the research interview it is to record the participants' experience in order to further scientific knowledge. Ethical guidelines on research arise from the need to protect research participants in a rule-bound conventional context

where the nature of the relationship is explicit. However the qualitative interview no longer follows these rules and the issue is no longer simply one of protecting the client but one of understanding the nature of moral agency within this new form of relationship. “Moral research behaviour is more than ethical knowledge and cognitive choices; it involves the person of the researcher, his or her sensitivity and commitment to moral issues and action’ (Kvale 1996: 117).

4.0 Ethical codes and the qualitative interview

Ethics, it is argued, are “ a codified set of value principles which have application to a nominated subset of people (professional practitioners)” (Francis, 1999:25) and their function is to guide towards high professional standards. The codes of ethics of professional associations are based on such utilitarian principles as self-determination and beneficence (Brickhouse, 1992). When we speak of ethics in relation to a profession we generally mean a professional code of conduct. For psychologists this is enshrined in the British Psychological Society’s Code of Conduct, Ethical Principles and Guidelines and is supplemented for counselling psychologists with the Guidelines for the Professional Practice of Counselling Psychology. The purpose of such codes is to set standards for behaviour and to provide a means by which ethical dilemmas may be resolved.

Thus, codes of professional practice will guide the therapist and client within a therapy situation and research ethics will guide researchers and participants in a research situation. Therefore ethical codes will only be effective in dealing with issues that can be compared to these set standards. They will be of little help in situations, such as clinical interviews, where complex ethical dilemmas arise as a result of a conflation of paradigms. Homan, (1991) argues that ethics was originally concerned with the

philosophy of morals encapsulated in the ethos of the profession but increasingly the literature has become dominated by the need to reach consensual standards for behaviour and research within the profession against which examples can be judged.

In order to deal with ethical issues arising from the qualitative interview methodology it is necessary to return to the base-line of morality itself from which ethical codes were originally derived and rather than focus on issues of client/participant protection ask questions relating to moral agency within relationships.

Current ethical guidelines in psychology and other professions draw heavily upon the medical codes of ethics first developed nearly two centuries ago (Homan, 1991).

The so-called medical experiments carried out by Nazi German physicians in the concentration camps during World War II sensitised the world to the problem of the mistreatment of human participants in research and gave rise to the Nuremberg code of medical ethics for human experimentation, (1946) (Judd, Smith & Kidder, 1991; Homan, 1991). The World Medical Association's Declaration of Helsinki of 1964 and 1975 is one of the most widely cited of medical codes (Downie & Calman, 1987) and calls for respect for the privacy and welfare of research participants as a moral obligation of researchers.

It is this notion of a moral obligation that seems particularly relevant to the qualitative interview.

Questionable practices with research participants arise because of the nature of the questions being asked, the nature of the setting in which the research is conducted, the kind of people acting as research participants, the research design, the method of collecting the data and the type of data being collected. In experimental research designs the factors mentioned above are usually proscribed fairly narrowly in order to

reduce confounding variables interfering with the experimental effect. However in research designs such as qualitative interviews the emphasis is less on the control of extraneous variables and more on the 'creation of an environment where the interviewee is encouraged to explore their feelings and express themselves freely without feeling judged or criticised' (Coyle & Wright cited in Gupta, 1998). Thus the roles of researcher and participant are much less clear and it is much more difficult to apply ethical guidelines for research to a situation which no longer adheres to the conventions of a research relationship.

A number of authors (Cassell, 1978; Barnes, 1979; Dingwall, 1980; Thorne, 1980; Walker, 1980; Wax, 1980; Kelman, 1982; Finch, 1986; Merriam, 1988; House, 1990) have argued that the ethical issues raised by qualitative research generally cannot simply be subsumed within the existing ethical codes. Professional codes of ethics for psychologists such as those of the British and American Psychological Societies do not tend to address the issues that arise in counselling psychology research. Lindsay and Colley (1995) surveyed BPS and APA members with regard to most commonly encountered ethical dilemmas and found that issues around confidentiality were most frequently cited. However, for BPS members the second ranking issue was research problems whereas for APA members it was dual relationships. In their conclusion Lindsay and Colley argued that traditional approaches to devising ethical codes were limited. Further evidence on the limitations of ethical codes was presented to the European Congress of Psychology in 1997 (Wassener & Slack, 1997; Sinclair, 1997; Antikainen, 1997; Lindsay, 1997). Lindsay & Clarkson, (1999) published a survey of ethical dilemmas encountered by UK psychotherapists and found that the most common dilemma was confidentiality and the second most common was dual relationships.

Although the focus of this research has been on ethical issues relating to practice rather than research it is interesting that the ethical issues relating to qualitative research methods also include confidentiality and dual-role relationships (Murphy et.al., 1998). If the ethical issues arising in both research and practice are the same this suggests the presence of a common factor which I would argue is the emphasis on a close relationship between the researcher/therapist and the participant/client. It is this relationship and the lack of clear purpose rather than the research or therapy itself which gives rise to ethical dilemmas.

4.1 Dual role relationships

The relevance of relationship to ethical issues has been addressed in the literature but it tends to focus on the undesirability of dual role relationships. Much has been written about the ethical problems of dual role relationships in which counsellor-client relationships are combined with, for example, supervisor-supervisee relationships or relationships of a sexual nature. Dual role relationships have been defined as relationships, 'in which there are two (or more) distinct kinds of relationship with the same person' (Tomm 1993). Ethical codes such as the American Association for Counselling and Development (AACD) come out strongly against dual role relationships involving sexual contact between counsellor and client. 'Dual relationships with clients that might impair the member's objectivity and professional judgement must be avoided and/or the counselling relationship terminated through referral to another competent professional' (AACD 1986). The British Association for Counselling Code of Ethics and Practice for Counsellors states, 'Counsellors are responsible for setting and monitoring boundaries between the counselling relationship and any other kind of relationship, and making this explicit to the client' (BAC 1992a B 2.2.5).

However as Kitchener, (1988) highlights, ethical codes tend to be silent on the types of dual relationship occurring between researcher/research participant and counsellor/client. One exception is that of the American Association of Marital and Family Therapy (1991) which urges the avoidance of dual role relationships in three areas: with clients, with students/supervisees/employees and with research participants (cited in Tomm 1993).

The literature on ethics in research does not deal directly with the relationship between the researcher and participants but does address some of the dynamics between the two and offers some guiding principals on how to treat research participants (Brickhouse, 1992).

The difficulty with the qualitative interview technique within a phenomenological frame is that the nature of the relationship between the researcher and participant appears to have weak boundaries due to the aims of the methodology. These aims are focused generally on promoting the development of a close relationship which encourages the participant to tell her story and for the researcher to develop an empathic understanding of the participant's life experiences. The researcher occupies the dual roles of researcher and therapist and the participant the dual roles of participant and client. However, neither of these roles is made explicit and expectations are confused. Therapists hold a special position in client's lives and qualitative researchers are similar in that they are witness to the client's story which may be one of pain and distress. In this way Bordeau, (2000) argues that the dynamic of the research interview is similar to the dynamic of the therapeutic session and quotes examples of researchers' admissions of violation of ethical principals whilst carrying out research. For example, Johnson's (1975) admission of a sexual relationship with a participant while researching social workers in a government agency and Matocha's (1992) description of how she

became more a friend and therapist when she was researching caregivers for persons with Aids, (cited in Bordeaux, 2000). Although role theory predicts that the problem with dual role relationships is that one individual is simultaneously or sequentially participating in two role categories that could conflict the situation here is more complex. The dual role is actually encouraged in qualitative interviewing but the breakdown of boundaries between researcher and therapist creates role confusion which increases the potential for ethical dilemmas.

In a very open and honest account of experiences of researching the area of male survivors of childhood sexual abuse, Kim Etherington shares the dilemma of choosing between responding as a therapist or as a researcher,

‘...my previous training has been like a double edged sword. On the one hand, without it I may not have achieved the depth and quality of interviews, and I may have caused some damage. On the other hand, it has been difficult at times to hear subjects (sic) talk about resigning themselves to their condition without exploring their feelings and challenging their blind spots and assumptions’ (Etherington 1996:342).

Within this boundary confusion exists a dynamic between researcher and participant which is less likely to occur in a more formal research design. Researcher and participant have a more reciprocal and reactive relationship. Doing the research changes the nature of the relationship, the research question, the participants and the findings themselves. This impact of one individual on another raises moral issues that transcend ethical codes of practice. This impact can only be predicted when an in-depth understanding is gained of the nature and intensity of the influence that the researcher and participant have on one another.

4.2 Autonomy and Responsibility

Ethical codes generally cover issues relating to autonomy and responsibility under

the heading of 'informed consent'. The elaboration of the principle of informed consent also originates in the Nuremberg Code of 1946. The ten-point Nuremberg Code attempted to outline permissible limits for experimentation with human subjects and the principle of informed consent was widely adopted in the professional codes governing medical and social research and practice. The basic elements of informed consent have been simplified to the four presented by Homan (1991):

The definition of 'informed' is a) that all pertinent aspects of what is to occur and what might occur are explained to the subject and b) that the subject should be able to comprehend this information. The definition of 'consent' is: a) that the subject is competent to make a rational and mature judgement and b) that the agreement to participate should be voluntary, free from coercion and undue influence.

Although this appears perfectly reasonable and fair on the surface, in reality there are many situations in which it is difficult to adhere to these principles. Within psychological research the design of the study is often dependent on the participants being unaware of its true purpose. In qualitative interviewing techniques the emphasis is on developing a rapport with the participants, '... to enable them to forget the definition of the situation as research' (Homan 1991:76).

Informal interview styles have the advantage of putting the participant at ease to the extent that material which might be withheld in more formal settings is willingly offered - as if to a friend. Although participants are informed at the beginning of the process, as to the purpose of the interview and the destination of the material revealed in the interview, once things get underway such are the skills of the interviewer, these details can easily be forgotten, 'Subjects do not necessarily feel the intrusion upon their space or know how much of their lives they are exposing' (Homan 1991: 67). The research

design and the relationships between researcher and participant unfold during the progress of the interview and often cannot be predicted at the outset (Brickhouse, 1992).

Finch, (1993), in her study of clergymen's wives, reports participants' comments relating to the ease of talking to the interviewer and finding the process a welcome experience. The effectiveness of the research method depends on the success of the researcher in facilitating the participant in disclosing significant personal details relating to the research topic, a task approached through the development of a trusting researcher-participant relationship. As Finch acknowledges, the very success of the enterprise opens up the participants to the risk of exploitation, 'These techniques can be used to great effect to solicit a range of information (some of it very private) which is capable of being used ultimately against the interests of those women who gave it so freely to another woman with whom they found it easy to talk' (Finch 1993" 174). Of course, the researcher is aware of how much personal material is being exposed and the responsibility to protect the participant should ordinarily lie with them. However, the process of informed consent, originated to protect the research subject, now allows the researcher to be relieved of such responsibility. After all the participant has signed a consent form to say they agree to participate, it is not up to the interviewer to judge whether the material is too personal to record. As Homan succinctly concludes, 'An ethic which relies upon the sensitivities of subjects to protect their own privacy thus exonerates the researcher who alone may be aware of how invasive an investigation has become' (Homan 1991:94). The principle of informed consent ultimately, as Homan argues, works more for the protection of the researcher than the researched. It allows an abdication of responsibility by the researcher for the participant's welfare. LaRossa, Bennett and Gelles, (1981) addressed the issue of ethical dilemmas in relation to qualitative family research and on the topic of informed consent suggest that the

difficulty for qualitative researchers is not knowing themselves at the outset where the interview or observation will lead. Participants cannot consent when it is unclear what they are consenting to. Participants may agree to take part in a qualitative interview believing that they retain some power over the situation but La Rossa suggests that in reality the subject is in a position of relative powerlessness in relation to the researcher and the likelihood of refusal to take part or withdrawal from the interview is very small. The opposite view is taken by Brickhouse (1992) who suggests that ethical codes presume that researchers have uni-lateral control over the research situation but in fact without the participants there would be no research and this fact positions the participant in a powerful relationship to the researcher. In qualitative interviews the relationship between the researcher and participant is on a more equal footing and dynamics of power may be more complex.

Again, the pertinent issue here seems to rest with the nature of the relationship between the researcher and participant and the evolving dynamic of that relationship as the interview proceeds. The lack of predictability involved in the research design renders the notion of informed consent, at least in its original context, redundant. Researcher and participant are both potentially vulnerable in this situation but both also possess some power. The flexibility of the roles makes the relationship risky but both parties retain some autonomy and responsibility. The ethical dilemmas lie in concepts of relationship and interpersonal interaction rather than in the unitary notion of informed consent.

5.0 Conclusion: the scientific value of the qualitative interview in counselling psychology research

The case presented here is that the qualitative interview as used in counselling psychology research is a hybrid creature which is part research tool and part clinical interview. As a result such an interview positions researchers and participants in dual roles that may create a crisis of identity. The boundaries of the interview are fluid and at times may resemble research and at other times a therapy session. This fluidity and conflation of paradigms create ethical dilemmas which would not arise in either paradigm separately.

It would seem that the potential for causing distress through in-depth research techniques is high and includes potential harm to the participant and the researcher. Guidelines, contracts, ethical codes and practices have developed over many years to protect the vulnerabilities of the client and the counsellor in the therapeutic relationship. However, little has been written about the ethical issues arising from the growth of phenomenological research in psychotherapy and counselling psychology. Social scientists have conducted this style of research for many years and researchers in psychotherapy could learn much from their experiences. However, there are unique aspects to the counselling research paradigm which require a more specific exploration of its ethical implications and the literature reviewed here suggests that there has been little attention paid to the complexity of this ethical situation.

A research methodology has scientific value in terms of the nature of the questions which it can answer, the rigour of the design and procedure which it embodies and the boundaries around the interpretation of the data. Within such a paradigm ethical issues focus around notions of participant protection and ethical guidelines are based on risk/benefit analysis whereby the moral principals of non-maleficence and beneficence are combined to give the notion of a balance between scientific benefit and potential for harm (Beauchamp et. al. 1982). When a research methodology no longer fits within

this paradigm then its scientific value must be diminished and the ethical issues raised are beyond the scope of ethical guidelines.

Counselling psychology research has grown out of the fundamentally empiricist foundations of psychology itself and has much to offer to the development of scientific knowledge within this paradigm. For example the hypothetico-deductive approach can be applied to the therapeutic process by developing theories and then testing them against data collected from therapy sessions in the form of transcripts. In this way, although ethical issues still have to be addressed they are contained within the realms of the scientific model and will be covered by research guidelines.

The question that counselling psychologists must engage with is how much scientific value remains in research which is conducted outside of this paradigm. Once the boundaries between researcher and participant become flexible the relationship has become something other than a research one. We may gain a deeper understanding of a client's world by using techniques such as qualitative interviews but can we argue that it is science and are the complex ethical issues involved justified?

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