# Discursive Psychology: Meta-theoretical Applications for Clinical Psychology

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## Abstract

This thesis proposes how Rom Harré's meta-theory for (social) psychology (Discursive Psychology) might be applied to the typical concerns of mainstream Clinical Psychology, namely, DSM IV diagnosis; clinical formulation; treatment intervention; and therapeutic evaluation. Discursive Psychology is posited as an overarching meta-theory for the social institution of Clinical Psychology, which is conceptualized as a phylogenetic discursive artifact (Vygotsky, 1962). The conjunction of these two divergent paradigms forces novel, emergent elements which might be usefully applied in efforts at improving both theoretical and applied psychotherapy. This is possible since all psychotherapeutic activity must necessarily include two interrelated, implicit first premises; i.e., 1) social discourse; 2) persuasive rhetoric for motivating healthful change in therapeutic subjects on the part of the psychologist as therapeutic agent. Discursive Psychology therefore provides an ideal, subsuming meta-theory which might inform therapists attempting to integrate the strengths of diverse schools of psychotherapy into one coherent formulation since *social discourse,* therapeutic or otherwise, is the essential subject of its investigation. Discursive Psychology also informs Clinical Psychology through its rich empirical research heritage – this can be adapted for the pursuits of clinical work, thereby augmenting the Clinical Psychology discursive artifact still further.

This thesis attempts to explore the theoretical and pragmatic implications of these claims through philosophical argumentation and empirical investigation (case study analysis). This claim is possible given that optimal counterpoising of the meta-theoretical strengths and weaknesses of Empiricism, Rationalism (Scientific Realism) and Social Constructionism makes Discursive Psychology the ideal heuristic ('toolkit') for conducting practical clinical work, since the theoretical integration of diverse schools of psychotherapy is so facilitated. It is therefore claimed that 'discursive clinical psychology' provides a coherent, professionally accountable meta-theory for the concerted application of existing therapeutic principles, strategies and techniques ('tools') as these inform a range of psychotherapeutic schools of thought, thereby availing practitioners of an *optimal therapeutic discourse.* This might be fashioned into a 'working eclecticism' in psychotherapy devoid of the usual theoretical anomalies which plague clinical eclecticism. These assertions are demonstrated both philosophically (Part I) and empirically (Part II) in three detailed case studies of situations typically confronting the psychotherapist in contemporary clinical practice.

Chapter 1 reviews how three central philosophical contentions have been addressed in Clinical Psychology over the passed century; that is, biological versus social considerations; individual versus collective dimensions; and cognitive versus affective elements. A cursory historical analysis of the

following psychotherapeutic schools was undertaken in this regard: psychiatric, psychoanalytic, cognitive-behavioral, humanistic-phenomenological (client-centered, gestalt, existential), systems-theoretical (strategic, structural, Milanese, eco-systemic), narrative therapy, and, radical therapeutic deconstruction. The resulting analysis provides the philosophical substratum for the ensuing discussion outlining the theoretical basis of a possible discursive clinical psychology formulation.

The following three chapters therefore focus on Harré's meta-theory through a discussion of – his theoretical biography as this evolved over time into the mature Discursive Psychology formulation, and is outlined in Chapter 2; developmental concerns, and notions of psychological change more generally are considered in Chapter 3; the evolution and nature of the diverse research instruments ('tools') available in Discursive Psychology research methodology is discussed in Chapter 4. Chapter 5 is devoted to a theoretical synthesis of traditional Clinical Psychology activities with those of Discursive Psychology. These notions are integrated conceptually with the assertions made in the preceding philosophical and theoretical review into a coherent discursive clinical psychology formulation, which concludes Part I of the thesis. This provides the theoretical template for guiding therapeutic discourse during the process of facilitating discursive therapy interventions, and is demonstrated in the ensuing case study illustrations and discussion.

Part II opens with an outline of the empirical research procedure adopted as this changed over time (Chapter 6), followed by three further chapters devoted to a discursive clinical psychology analysis of each case study unit. These function as illustration of how traditional forms of psychotherapeutic intervention typically used by the contemporary psychotherapist might be constructed from a Discursive Psychology position. That is, Chapter 7 discusses the collective unit – a depressed child and his family, and includes individual play and collective family therapy sessions; Chapter 8 focuses on the dyadic unit – a sparing couple attempting to create a reconstituted family, and includes couples therapy sessions; Chapter 9 considers the individual unit - a certified psychiatric patient whose disability grant is threatened, and includes examples of individual psychotherapy sessions. Each case study includes full transcripts of sessions, and is enclosed on a CD-ROM using the Adobe Acrobat™ PDF format. The transcripts are indexed to clinical discussion during the course of the chapters, focusing on research, diagnosis, intervention and evaluation, as informed by discursive therapy principles, strategies and techniques.

The final chapter provides a brief critical review and summary evaluation of the discursive clinical psychology project as a whole, and outlines the way forward.

# PART I

# THEORETICAL ORIENTATION

Chapter 1

# Discursive Psychology: Meta-theoretical Implications for Clinical Psychology

This thesis deals with the conjunction of two unlikely occurrences; that is, practical considerations of clinical intervention (psychotherapy) and the theoretical and meta-theoretical contributions of Rom Harré, one of the seminal theoreticians of the Discursive Psychology movement. For those with a working acquaintance of either terrain separately, questions pertaining to their conjunction, their interrelation and their possible contrapuntal resonance would seem to be distanced. Furthermore, Harré has not done much to enter the practical domain of clinical spheres, nor has the area of psychopathology and clinical work been other than cursorily investigated in Harré's publications. This thesis therefore argues that there is merit in conjoining these two unlikely domains in order to both articulate a useful meta-theory for conducting clinical work, and to clarify, empirically probe and illustrate Harré's assertions as these occur in operation.

Harré has been a prolific writer for some twenty-five years and has maintained a keen sensitivity to crucial developments in epistemological concerns in the human sciences. Any consideration of Harré of necessity, therefore, must attempt to unravel and grapple with the epistemological clash between the Positivist tradition on the one hand, and the emerging cluster of challenging meta-theories and epistemological assumptions of Social Constructionism on the other. Indeed it is argued that this integrative project has knitted together essential elements from the dual pillars of Positivism; i.e., Empiricism and Rationalism (Realism), with the more recent issues raised by discourse analysis, post-structuralism, post-modernism; that is, Social Constructionism, or what Harré refers to as 'the second cognitive revolution'.

Harré's body of work provides an important position on theories of self as it has emerged over time, and both challenges and incorporates Positivist as well as Social Constructionist theories of self into a coherent meta-theory which, apart from its epistemological clarity, provides a potentially useful hermeneutic for Clinical Psychology. That is, Harré's meta-theory serves as a useful therapeutic 'toolkit' (conceptual overview) for organizing clinical interventions while different mainstream schools of psychotherapy provide useful therapeutic 'tools' (i.e., principles, techniques and strategies) for effecting psychological change in those cases typically confronting the clinical psychologist in day to day practice.

More specifically, certain *central implicit meta-theoretical contentions* exist across all mainstream psychotheory at a meta-theoretical level which have not been adequately resolved or accounted for by any *one* psychotherapeutic school of thought. Harré's meta-theory provides this crucial overarching conceptual organization and formally reconciles the following primary meta-theoretical contentions for which any psychology meta-theoretical framework should systematically account:

- *biological versus social factors* - by definition, human beings are social animals and therefore both physiological as well as group and institutional factors need to be considered in any theoretical formulation explaining human psychology;
- *the individual versus collectives* - given each human being's physical embodiment, the human world necessarily includes individual psychological processes (intra-personal) as well as collective processes (inter-personal) - the mutual interaction of these two principal psychological domains requires theoretical explanation;
- *emotional versus thinking processes* - although Western psychological theorizing has tended to dichotomize cognitive and affective factors (Stainton-Rogers R., Stenner, Gleason & Stainton-Rogers W., 1995; Stainton-Rogers, 1992), the two aspects are not necessarily *a priori* opposites; nevertheless, any overarching meta-theory needs to account for these two dimensions of Western psychotheory given philosophical efforts at the integration of different psychotherapeutic schools which have evolved in the West;
- the *mutual inter-relatedness* of all these primary conceptual contentions which necessarily comprise essential elements for any conceptual-theoretical formulation of the psychological operation of the human world.

It is argued that unlike any other existing meta-theoretical formulation in psychology, clinical or otherwise, Harré's meta-theory for (social) psychology addresses *all* of these pivotal structural contentions; that is, Discursive Psychology provides an overarching meta-theory for the cohesive integration of the respective strengths and weaknesses of the various mainstream psychotherapeutic approaches as each attempts to address these central meta-theoretical conceptual contentions confronting any investigation into psychology more generally; these meta-theoretical assertions necessarily inform crucial theoretical and practical psychotherapeutic considerations for Clinical Psychology practice and therapeutic outcomes for patients.

This is possible given that Discursive Psychology understands all psychological phenomena in the human world to be constituted through *social discourse* - Clinical Psychology is simply a discursive institution like any other, with its attendant story-lines, speech-acts and positions. Indeed, as a social institution, Clinical Psychology is defined through its activity within human society which involves attempts at providing relief for people's life problems and any resulting distress through the

therapeutic intervention of one or more trained clinicians using more or less circumscribed, mandatory psychotherapeutic techniques and principles from various schools of thought. Indeed as a phylogenetic socio-cultural discursive artifact (Vygotsky, 1978, 1962), the institution of Clinical Psychology has witnessed attempts at successive improvement on preceding schools of thought, at least according to its developers, for both practical psychotherapy and epistemology; each story-line has attempted to redress any faulty epistemology in their efforts to find alternative ways of improving people's sense of wellbeing and life adjustment through psychotherapy. For example, Freud attempted to improve on the medical model of the day, while behaviorists contested psychoanalytic epistemology as vague and not conducive to empirical testing and embraced rather radical Empiricism. In turn, these notions were contested as alienating and mechanistic by humanistic-phenomenonological theoreticians; as a result, person-centered therapeutic strategies, techniques and principles emerged within therapeutic discourse. The systems-theoretical school subsequently argued for the necessary inclusion of interpersonal systems of communication since individuals are inevitably situated amongst others and preceding psychotherapeutic formulations had primarily focused on intra-personal considerations. Other Social Constructionist approaches attempted to incorporate the patient's voice (e.g., narrative therapy) given the imposition of a constructed reality onto voiceless patients when Realist theories such as psychoanalysis and structural systems theory were operationalized in therapy; patients were rather encouraged to re-author their own stories. Therapeutic deconstruction analysis elaborates upon these radical Social Constructionist ideas and focuses on dismantling broader power relations implicit within social discourse in order to assist re-authoring efforts and in so doing, provides distress relief for individuals. However, while each theoretical framework and resulting therapeutic stance attempted to improve on the other, no one school of Clinical Psychology has been able to address all pertinent issues:

> *"The fact is that none of the theories to date address the whole spectrum of abnormality - they are each limited by their focus".* (Carson, Butcher & Mineka, 2000, p 116)

Each of these psychotherapeutic schools can be conceptualized as possible story-lines through which the generic activity of 'Psychotherapy' might occur. These each, in turn, determine a defined set of possible speech-acts whereby various discursive positions can be taken up along any psychotherapeutic story-line location in order to effect the desired therapeutic change for patients as this occurs within the interlocutory context of the psychotherapeutic consulting room. Indeed, clinician/s and patient/s are in constant discursive interchange within their formal relationship as interlocutors and, therefore, are involved in ongoing discursive positioning activity in relation to one another no matter which psychotherapeutic story-line is adopted. Each psychotherapeutic school therefore provides extremely useful therapeutic strategies, principles and techniques for effecting healthful psychological change within the broad discursive institution of Clinical Psychology albeit

that each is indeed *radically* different to the other in matters of clinical formulation and therapeutic positioning. This is principally a function of the rhetorical power implicit within any speech-act occurring in the psychotherapeutic context to effect healthful change - this is the discursive common denominator unifying all clinical story-lines, from psychiatry and psychoanalysis to narrative therapy and therapeutic deconstruction analysis; that is, persuasion towards healthful psychological change through contact with an agent of change, namely, the psychotherapist, always involves *discursive* interaction, of one sort or another - discursive clinical psychology therefore places generic 'therapeutic discourse' at the epicenter of therapeutic activity thereby optimizing possibilities for healthful and effective psychotherapeutic outcomes.

This philosophical position would therefore suggest that dispensing with any psychotherapeutic story-line in favor of one or another school of thought, ultimately compromises any super-ordinate therapeutic discourse by limiting the possible range of therapeutic positioning 'tools' for effecting healthful improvement in patients' life adjustment. Moreover the speech-acts, principles, techniques and strategies of each school of thought can be used *eclectically* although, unfortunately, no meta-theory from any one school of thought is sufficiently broad to embrace every other school of thought. Any so-called 'psychotherapeutic eclecticism', therefore, is an intrinsically arbitrary process since no overarching philosophical schema exists for the co-ordination of therapeutic activity and, therefore, by definition, cannot be considered 'professional'. Clinicians must therefore choose between the twin pitfalls of restricted clinical application given the psychotherapeutic limitations of each school of thought (story-line) or an ad hoc eclecticism lacking professional accountability.

> *"Typically, those using an eclectic approach make no attempt to synthesize the theoretical perspectives. The approach seems to work best in practice rather than in theory; the underlying principles of many of the theoretical perspectives are incompatible as they now stand. Thus the eclectic approach still falls short of the final goal, which is to tackle the theoretical clutter and develop a single, comprehensive, internally consistent viewpoint that accurately reflects what we know empirically about abnormal behavior".* (Carson, Butcher & Mineka, 2000, p 116)

This thesis therefore illustrates how it is both theoretically and practically possible to liberate the active use of the discursive strengths of each school of thought during therapeutic positioning in the context of a possible *discursively* orientated therapy. Discursive Psychology therefore places discourse at the *center* of therapeutic activity and not merely as a vehicle for psychotheory, while also limiting the respective weaknesses of the different psychotherapeutic schools of thought for the successful articulation of therapeutic positioning in any specific case or over time given the changing needs of the patient/s. Furthermore, Discursive Psychology provides a range of research techniques

and principles which can be usefully applied to clinical work within the overarching notion of 'discursive clinical psychology' and augment the range of psychotherapeutic 'tools' available to the discursive therapist.

What follows in this chapter, therefore, is a philosophical overview of both Positivist and Social Constructionist psychotherapeutic schools of thought as these pertain to the primary meta-theoretical contentions implicit within the generic institution of Clinical Psychology; that is, from conservative Empirical and Realist approaches through to radical Social Constructionist orientations, and in order of historical evolution (more or less):

- the psychiatric (medical) model;
- psycho-analytic/ -dynamic schools;
- cognitive-behavioral approaches;
- various humanistic-phenomenological positions, namely, client-centered, gestalt, and existential;
- systems-theoretical schools of thought, that is, strategic, structural, Milanese, eco-systemic;
- narrative therapy;
- and, finally, radical therapeutic deconstruction analysis.

Discursive Psychology's position will be discussed now in relation to the central meta-theoretical contentions within psychotherapy more generally, before turning to a comparative analysis of how the story-lines of each of the above schools of thought address these central philosophical tensions thereby defining the meta-theoretical limits of their discursive efficacy as guides to therapeutic action.

## DISCURSIVE PSYCHOLOGY'S PHILOSOPHICAL POSITION

Harré (1991, 1983, 1979) proposes a meta-theory of psychology which maintains a useful balance of individual and collective considerations. He posits the notion of personal agency within moral order belief systems or discursive 'story-lines' as a conceptual schemata which resolves the individual-collective schism. In this formulation, individuals are understood to be socialized through discursive processes which are founded upon language, and, as a function of language, can transform the social structures which surround them. Thus Harré (1990) maintains that all human activity can be reduced to two primary elements: *discourse and physiology.* The latter refers to the corporeal and biological world as well as the collectively held moral order belief systems or story-lines which surround the individual as real entities. The former involves the dialectical discursive interactions of individuals within the confines of the social world; it is through discursive processes that individuals are able to

articulate personal agency within collectives. Personal agency involves the volitional acts of individuals within the confines of the discursive worlds which surround them:

> *"People operate with the meanings available to them in discourse and fashion a psychological life by organising their behaviour in light of these meanings and integrating them over time. The result of the integrative project is a personality or a character that is, to the extent permitted by the discursive skills of the subject/agent, coherent and creative. The ideal is a psychological life with the character of an artistic project and not merely a stream of experiences and responses to stimulation". [Harré & Gillett, 1994, p. 143].*

This formulation therefore places the individual at the center of collective activity and unifies the individual and collective dimensions within one coherent philosophical system. Intrapsychic 'talk' or discourse involving emotional and cognitive dimensions is understood to involve *private* discourse while interpersonal 'talk' involves *public* discursive interactions and also necessarily includes thinking and emotion; the two levels are complexly interactive yet unified within a discursive whole - both public-private and individual-collective dimensions subsists within the same psychological space, unified through language. The clinician therefore might enter this psychological space at any of these levels in order to effect useful change by engaging in *therapeutic discourse* - this has important implications for working with individuals and groups of people in psychotherapy. Furthermore, 'emotion' and 'thinking' are not dichotomized in this formulation but are understood rather to comprise a dynamic discursive unity (inter-functional semiotic system) and traverses both individual-private and collective-social discursive space. Similarly, biological considerations are understood within social-collective dimensions as these pertain to both the individual human being and broader social processes. Finally, the notion of 'personal agency' seems to be a central principle implicit within all schools of psychotherapy since all therapeutic efforts attempt to restore a sense of personal control and self-direction to the individual and/or groups of people seeking assistance from the clinical psychologist - clearly Harré's formulation has important implications for an eclectic formal unity amongst different schools of psychotherapy founded upon Positivist and Social Constructionist meta-theoretical positions.

Discursive Psychology's meta-theoretical assertions, however, also assisted in the development of a very practical research methodology; that is, *ethogenic and discursive research*, which is consistent with Discursive Psychology premises and assumptions. These research techniques are both practical and useful as a means of exploring the human psychological world and also function as a form of 'therapeutic discourse'. Consequently the work of Rom Harré appears to represent a cohesive theoretical and practical heritage upon which to develop a functional discursive therapy model;

together, sound theory and practical methodology should have profound practical implications for clinical work.

Fortunately Harré has been prolific in his production of written discourse since the early 1970's and has covered a vast amount of conceptual territory. As a philosopher of science, he has maintained a keen interest in meta-theoretical problems in psychology. This philosophical enterprise has resulted in a rich tapestry of thought on the philosophical heritage of the social sciences. In his work one finds a clarity of vision which coherently steers between the Positivist heritage of the past and the Social Constructionist movement of the late Twentieth Century, while still maintaining a firm grasp on Empirical methodology and operational concerns. Moreover, Harré appears to have managed to keep pace with important developments in cognitive psychology, and has articulated his personal agency in fine style, by integrating, formalizing and streamlining primary conceptual developments in psychology with his central model. Although Harré has not explored Clinical Psychology in much detail, the implications of his meta-theory and the scant but crucial references to mental illness in his vast work form the seeds for further growth and refinement of a possible discursive clinical psychology model.

Part I (theoretical orientation) of this thesis attempts to explore this possibility by reviewing Harré's work as it pertains to meta-theory (Chapter 2), psychological development (Chapter 3), research (Chapter 4), and, psychopathology and treatment (Chapter 5), while Part II (empirical research) focuses on three illustrative case studies demonstrating discursive therapy in action (Chapters 6-9), before concluding finally in Chapter 10 with a critical review and summary conclusion of the discursive clinical psychology project as a whole. We turn now, therefore, to consider firstly a philosophical overview of the different schools of thought discussed earlier in an attempt to briefly unravel some of the primary conceptual tensions implicit within their grammars as these pertain to discursive clinical psychology meta-theory, and in so doing, orientating the reader to the broad meta-theoretical arguments underlying this doctoral thesis.

**The Psychiatric Story-line**

Psychiatry as a product of the medical model places biological primacy at its epistemological center, and except for the recently appended 'relational' diagnoses (Diagnostic and Statistical Manual of Psychiatry IV: DSM-IV, 1999), on the whole, also tends to focus on the individual as unit of clinical analysis rather than collectives. Indeed these first premises are the meta-theoretical origins of psychiatric explanations pertaining to both thinking and emotion; that is, both are understood to arise as a function of individual biology, and idiosyncratic physiological differences (both inherited and

constitutional) explain all individual variation. For example, 'personality' differences within a circumscribed socio-cultural context are considered to be primarily biological/ genetic in origin.

While an attempt at including social factors through the adoption of the multi-axial diagnostic taxonomy in more recent editions of the *Diagnostic and Statistical Manual of Psychiatry* (i.e., DSM III, III-R and IV) has been made, generally speaking, its compilers have tried to maintain allegiance to the *International Classification of Diseases* (9th Ed.) (World Health Organization, 1997, 1978b) manual of both mental and physical disease, so to ensure psychiatry's compatibility with mainstream medical practice; biological factors are placed at the center of this formulation while social factors are given considerably less attention. Furthermore, a disease orientation is quintessentially implicated in any psychiatric reading of life adjustment problems for human beings and every effort has been made to bleed out subjective elements so to sharpen the objective disease metaphor; that is, by using only operational criteria for defining the different disorders included in the classification system. This means that the DSM system specifies the exact behaviors that must be observed for a given diagnostic label to be applied. Typically, a specific number of signs or symptoms from a designated list must be present before a diagnosis can be properly assigned. Therefore, although the DSM classification systems regularly change in order to accommodate new research information and clinical usefulness for the practitioner, essentially the psychiatric meta-theory conforms to the principles of hardcore Empiricism which initially informed the institution of Western medicine in modernity, given the socio-cultural trends during the Renaissance, the age of rationalism, and the attendant ascendance of the ensuing scientific paradigm in modern Western discursive institutions - any variation on DSM taxonomy always occurs within the confines of this broad epistemology.

Nevertheless, the psychotherapeutic strengths of the psychiatric story-line for the clinical discursive psychology project might include the following:

- a fairly consistent vocabulary for describing symptoms (speech-acts within a story-line) related to life adjustment problems which provides a useful discursive currency for communication between practitioners and for training purposes, for example;
- a functionalist orientation with clear criteria for 'illness, health and cure' provides a useful baseline from which improvement in clinical services can be regulated through data collection and Empirical analysis over time, through epidemiological studies, for example;
- and, where physiological anomalies obviously contribute to life adjustment problems (e.g., organic brain damage), medical interventions such as psychopharmacology and psychoactive medication prescription and monitoring can be extremely useful for improving individual life adjustment.

From an alternative position, however, these strengths might, paradoxically, be considered the principal weaknesses of the psychiatric model for the amelioration of life adjustment distress; that is,

- a fairly consistent vocabulary for describing symptoms related to life adjustment problems might comprise a discursive fiction, for example, which simply constructs people's life adjustment problems according to a discursive schema better suited to the treatment of the human body than the human mind. Indeed any discursive 'consistency' can simply be framed as discursive 'limitation';
- any functionalist orientation with clear criteria such as 'illness, health and cure' also relies on an implicit meta-theory which always informs any choices made in relation to categorical imperatives. Clearly medical metaphors contain implicit central notions such as the role of the practitioner as expert and the relative lack of symmetry in power relations between patient and healer. Furthermore, this implicit meta-theory considers certain disorders worthy of *naming* while others are not formally categorized at all. For example, 1) Kleinman & Good (1985) demonstrated that 'depression' (dysphoria) had radically different discursive meanings amongst Buddhists who considered dysphoria a positive first step towards worldly renunciation of pleasure, while Shi'ite Muslims in Iran understand dysphoria to be an inevitable religious experience when a person lives justly in an unjust world - the ability to experience dysphoria fully is therefore a marker of depth of person and understanding in this cultural discourse, and is by no means associated with 'illness'; 2) homosexuality was removed as a psychiatric disorder in 1973 due to the liberal human rights movement during the 1960s in North America and Europe, providing a spontaneous 'cure' for previously 'ill' gay people across the world albeit contrary to the central notions implicit within the principles of biological determinism;
- and, while medical treatment of physiological anomalies contributing to life adjustment problems may well be useful in certain cases, the all embracing biological paradigm for all ills, both mental and physical, can be severely restrictive at best and entirely fictional and unsubstantiated at worst; that is, while biological processes are indeed implicated in *all* human action, the body is not necessarily the optimal treatment site for life adjustment problems since our fleshly envelopes indeed make our experienced consciousness as discursive beings possible but do not account for all possible problems and treatment possibilities, for example, in the case of anorexia nervosa. Furthermore, the placebo effects of psychoactive medication are well documented as are the myriad unexplained side effects which therefore dilutes any so-called 'medical objectivity'. And where etiological roots are not exclusively organic in nature, the fact remains that distress symptoms are being treated rather than underlying generative mechanisms, such as dysfunctional familial communication and interaction, for example.

It is argued, therefore, that in view of the need for diversity in treatment possibilities so to accommodate the idiosyncrasies of specific situations, indeed any of the mentioned mainstream psychotherapeutic schools of thought might be considered to have both strengths and weakness for attending to the psychotherapeutic needs of the moment in any specific clinical case; that is, different forms of psychotherapeutic interaction are required for the *optimal* amelioration of specific forms of psychological distress. We therefore continue this philosophical discussion with regards to the other mainstream psychotherapeutic story-lines in light of Discursive Psychology meta-theory.

**The Psychoanalytic Story-line**

Since Freud's (Freud, S, 1979 (1911), 1984 (1915), 1973 (1933)) early topographical formulations, psychoanalytically orientated (psychodynamic) theoreticians have attempted to reconcile intuitive Empirical verification of the impact of social factors in psychological development with the overarching psychoanalytic meta-theory; that is, Jung (Jung & Jacobi, 1989) made the first contribution by positing the notion of a biologically programmed '*Collective* Unconscious' at the intrapsychic level, followed by transitional (Freud, A, 1972; Klein, 1932) and mature forms of object *relations* theory (e.g., Mahler, 1976; Winnicott, 1966) which also attempted to solve the social-collective conundrum. Later attempts included more *interpersonally* orientated formulations, focusing on wider social influences specifically although theoretical focus was still concentrated at the intrapsychic level (e.g. Erikson, 1975; Sullivan, 1964), and most recently, psychoanalytic approaches that attempt to integrate discourse analysis into their theoretical and therapeutic positioning (e.g., Lacan (Bowie, 1991; Ragland-Sullivan, 1986)) so to incorporate social factors. The psychoanalytic cluster of psychotherapeutic approaches tend to involve typically the following notions, therefore:

- a focus on the *individual* rather than collectives;
- *unconscious* motivation;
- a focus on *early development* whether in infancy, childhood or adolescence;
- *psychopathology*;
- notions around *affectivity*; that is, libidinal drives in concert with 'emotions' as intrapsychic signals (e.g., excitation of aggressive or sexual drives leads to anxiety signals (guilt) given internalized superego transgressions);
- necessary inclusion of an *expert therapist* who ultimately understands the patient's psychological process, beyond analytic subjects themselves, as might a medical doctor in the diagnosis and treatment of diseases of the body, for example;

- rely on *Positivist (Realist)* epistemological assumptions in that the theoretical models characteristically formulated are based on certain specified assumptions about human development given the limits of biological determinism;
- premise specified developmental *stages* although not all schools of psychoanalytic thought agree as to the specific age of onset and termination of each successive stage, or their content and relevancy for subsequent psychological development.

Any Lacanian-based structural formulations involving efforts to integrate discourse into the psychoanalytic equation, however, still maintain a fundamentalist allegiance to typical psychoanalytic notions, such as 'penis envy' in woman, and the infant's 'primary envy' of the creativity of the breast, 'Oedipal conflicts', 'oral, anal and phallic sadism and masochism', for example, etc.. Any discursive considerations are simply mapped onto these notions given that Freud's initial conceptualization of the operation of the 'superego' in relation to the 'id and ego' included social factors. Lacan later re-formulated the operational notion of the superego and ego in terms of social discourse. In this and other psychoanalytic formulations, cognition arises as a function of individual libidinal affectivity (fantasy) in early infancy in order to facilitate biological (libidinal) adjustment to interpersonal and environmental demands - any subsequent thinking during later development maintains this affective primacy and cognition is typically relegated a secondary position to these primary processes. Consequently, Lacan posited that indeed the Unconscious is structured *like* a language since primary process has no alternative conduit into the world of others given biological constraints; as such the individual subject is forever split-off from intrinsic, essential aspects of self as defined by psychoanalysis by joining the world of 'the Other' through the articulation of language specific to any socio-cultural context. This has led to psychoanalytic readings of diverse cultural forms, for example, intimate relations in India (Kakar, 1989), and to therapeutic developments during any psychoanalysis (Gibson, 1993; van Zyl, 1990), by considering the diverse cultural expression of these indubitable psychological processes. Any psychoanalytic orientation towards 'discourse' is therefore yet another permutation in the long line of theoretical efforts to account for social factors in psychoanalysis and therefore do not present any radical shifts towards the therapeutic operation of discourse in action as is suggested for the discursive clinical psychology project as outlined in this thesis.

Needless to say, psychoanalytic approaches cannot be proven Empirically and therefore amount to a form of intellectual dogma, which has encouraged Harré indeed to dismiss psychoanalysis as arrant nonsense as its implicit meta-theory can be traced back to Viennese moral order (Harré, 1991) - for example, the 'Dr Jeckyl and Mr Hyde' story-line also metaphorically index these Victorian socio-cultural story-lines, as do many Gothic novel characters, and so too the persecutory introjects of the

psychoanalytic Unconscious (Stainton-Rogers, R. & W., 1992). Although his sentiments are more than understandable, psychoanalysis in action as a possible story-line for therapeutic discourse during the process of psychotherapy does indeed provide extremely useful discursive concepts, principles and processes for effecting psychological change given the powerful persuasive rhetoric implicit in any analyst-analysand interlocution. For example, patients indeed cannot by definition contest the speech-acts of the psychoanalytic therapist given his expert knowledge of the Unconscious, ego-defense mechanisms etc. - the psychoanalytic story-line is therefore indeed useful as a discursive therapy positioning device, albeit a discursive fiction, where the therapeutic moment presents itself and the discursive therapist so decides. This is mostly a function of the popularization of psychoanalytic concepts, such as 'unconscious motivation' which has become part of social discourse more generally speaking (Moscovici, 1988, 1976, 1961).

Furthermore, recent ideas surrounding the *'unsaid'* or *'dialogic unconscious'* (Billig, 2000, 1999, 1997, 1996, 1995) of any story-line have breathed new life into archaic psychoanalytic notions; that is, as people learn the correct social metaphors through collective conversation, so too is the *(in)*correct or obverse discursive position articulated - all story-lines are by definition dialogical. In this sense, therefore, unconscious motivation is applicable to purist discursive approaches since the 'discursive obverse' formally exists as the 'unsaid' yet to be 'said'; that is, the 'unconscious made conscious'. Furthermore, although developmental stages are undoubtedly socially constructed and therefore lack any identified correlation with reality (Morss, 1996; Burman, 1994), retrospective discursive analysis of the socio-cultural history of story-lines, positions and speech-acts held by individuals, groups and institutions, remains a central analytic endeavor in any discursively orientated psychotherapeutic encounter - this clearly provides new meanings for pivotal psychoanalytic notions such as the 'repetition compulsion'. So too are the notions of 'transference and counter-transference' useful in discursive therapy when simply reformulated in terms of conversation analysis between two interlocutors, for example. Further, certain psychoanalytic therapeutic techniques such as 'free association', 'dream analysis' or the unpacking of 'Freudian slips' as well as general working principles such as 'making the unconscious conscious' or 'following the patient', for example, can be reinterpreted for the discursive clinical psychology project, with undiluted loyalty to *discourse* at a theoretical and meta-theoretical level. These ideas are more fully outlined in Chapter 5 and the case study analysis which follows in Part II of this doctoral thesis.

**The Cognitive-behavioral Story-line**

While behaviorist interventions predate the emergence of cognitively orientated psychotherapies, the term 'cognitive-behavioral' has tended to become the discursive currency denoting *'learning'* for effecting healthful psychological change whether focusing exclusively on behavior or cognition, or a

combination of both aspects during psychotherapy (Carson, Butcher and Mineka, 2000). *'Faulty or dysfunctional'* learning is understood to arise as a function of the individual's interaction with the 'environment' both past and present, and while social aspects are considered within the overall cognitive-behavioral formulation, focus is essentially directed towards *individuals* and their capacity to learn more functionally adaptive ways of behaving and thinking and not on collectives - 'cognition' is therefore understood to occur within the individual at an intrapsychic level and is deemed more or less functional given adequate or inadequate internalization of adaptive social and concrete learning opportunities for life adjustment and the comparative absence of psychiatric symptoms in day to day functioning. Similarly, biological factors are relegated a secondary position and only considered in relation to the promotion or inhibition of learning new, more 'adjusted' behaviors and/or formulating more 'rational' beliefs; for example, 1) where a patient is given electric shocks (e.g., when treating different forms of behavioral fetishism) or medication (e.g., Antabuse to prevent ingestion of alcohol) during aversion therapy (Bandura, 1969); or, 2) patients being informed through therapeutic 'talk' during rational emotive behavioral therapy (Ellis, 1979, 1970, 1962) that adequate attractiveness as a physical specimen is all that is necessary for life happiness.

Cognitive-behavioral therapeutic approaches include a vast range of empirically researched therapeutic principles, techniques and strategies that can be usefully applied by the discursive therapist during any discursively orientated therapeutic positioning encounter through mediating life skills, for example, and are discussed in Chapter 5 and during the course of Part II. This is possible since at a meta-theoretical level, cognitive-behavioral principles can be adapted and integrated with discursive notions since the cognitive-behavioral story-line places 'cognition' and 'behavior' at the epicenter of therapeutic activity - Discursive Psychology can comfortably subsume cognitive-behaviorism since 'discourse' typically involves a conceptual synthesis of both 'cognition' and 'behavior' bound together as a formal unity with 'emotional' elements; that is, behavioral responses arise as a function of discourse while any behavioral performance necessarily relies on discourse in order to interpret the social meaning of the behavior - these aspects are discussed more fully in Chapter 2. Furthermore, 'emotion' is placed at the margins of the cognitive-behavioral formulation and is believed to be regulated, monitored and controlled by thought processes, *exclusively*; that is, cognitive-behavioral therapists attempt to correct chunks of 'faulty' or 'irrational' behavior and thinking during therapeutic efforts in an attempt to restructure problematic emotional responses (e.g., anxiety (Ellis, 1970) or depression (Beck, Rush, Shaw & Emery, 1979)), for example, as experienced internally by the individual - the *reciprocal* interchange between emotion and thinking is not typically addressed since cognitive and behavioral changes are understood to ultimately control emotion-related factors.

While these ideas are clearly Realist in meta-theoretical orientation, any explanatory models for the occurrence of behavioral and thinking shifts, changes, anomalies and therapeutic failures, for instance, are de-emphasized in favor of observable, measurable and rateable antecedents to and the consequences of specific forms of behavior and/or thinking processes for symptom relief as empirically tested. In this way cognitive-behavioral clinicians hope to circumvent explanatory solipsism contained in psychoanalytic formulations, for example, thereby maintaining Empirical rigor in their experimental efforts to effect 'cures'. Indeed this staunchly Positivist (Empiricist) meta-theoretical emphasis simultaneously comprises the story-line's primary strength *and* weakness; that is, as a counter movement to the blind faith of psychoanalysis, focused outcomes based research provides a quintessential orientation for the clinician seeking practical therapeutic solutions for his patients (e.g., Wolpe's (1958) 'systematic desensitization' technique which was empirically developed and tested as an effective treatment for phobic anxiety disorders), yet, on the other hand, the lack of explanatory theorizing or identification of formal, underlying generative mechanisms together with the all embracing focus on mechanistic re-descriptions of so-called 'discrete behavioral and cognitive *entities* comprising faulty learning', can limit the critical application of therapeutic possibilities in similar ways to those involved in symptomatic relief through psychiatric medication, for instance. That is, symptoms are often treated and not the ultimate causes of so-called 'faulty learning', which might involve more complex, subtle factors such as social or personal *identity* issues in the treatment of sexual or substance-related disorders (e.g., see Chapter 9), for example, which might interfere in individual patients' ability to both learn and integrate the new discursive material mediated through the cognitive-behavioral therapeutic encounter into their day to day lives given their contrary social and personal identity discursive investments.

Cognitive-behavioral meta-theoretical premises therefore also determine that therapeutic interventions should rely on set behavioral or cognitive templates such as those outlined in stress-inoculation therapy (Meichenbaum, 1977), rational emotive behavior therapy (Ellis, 1970), or Beck's cognitive therapies (Beck et al., 1979). These are all circumscribed by social beliefs which provide discursive definitions for the implicit social meanings involved in 'faulty learning' or 'irrational, illogical and unrealistic beliefs', for instance, or their 'correct' discursive obverse. In other words, cognitive-behaviorism assumes that there is a formal definition for 'adjusted' and 'maladjusted' ways of operating and show no compunction in prescribing these templates as psychiatric 'cure-alls', yet the discursive artifacts emerging from therapeutically orientated cognitive-behavioral Empirical studies have been based on studies conducted primarily in North American and therefore reflect the moral order belief systems implicit within the North American discursive fabric and, consequently, do not necessarily have wider ethnic relevancy when working towards therapeutic application and symptomatic relief.

In summary, the cognitive-behaviorist psychotherapeutic story-line is undoubtedly practical and can be usefully subsumed into discursive therapy since from the outset, Discursive Psychology investigations attempted to redress any implicit theoretical and meta-theoretical problems pertaining to explanatory depth and ethnocentricity within cognitive-behaviorist positions and the prevailing Positivist paradigm more generally while still maintaining keen emphasis on scientific rigor and practical application. The genesis and process of Harré's (and others) efforts at challenging the entrenched Positivist paradigm, the ultimate discursive genesis of the cognitive-behavioral therapeutic story-line, is discussed more fully in the following chapter.

**The Humanistic-phenomenological Story-line**

In an effort to find psychotherapeutic alternatives to psychologically 'alienating' therapeutic paradigms such as psychiatry, psychoanalysis and cognitive-behaviorism which, it was understood, tended to place the individual within mechanistic discourses reliant on 'objective', 'expert' therapists to effect psychotherapeutic change, humanistic-phenomenologically orientated theoreticians attempted, alternatively, to place the *experience* of the human subject ('client', not 'patient') at the epicenter of their meta-theoretical formulations. That is, the psychotherapist serves a *facilitative* function while the client is responsible and free to create healthful changes in their life adjustment as perceived by themselves - the therapist simply reflects their journey and provides a safe interpersonal encounter for this process to occur. Specifically, the humanistic-phenomenological psychotherapeutic schools of thought include client-centered (Rogers, 1980, 1955, 1942), gestalt (Perls, 1976, 1971, 1969) and existential (based on broad philosophical notions developed by Sartre (1958); Frankl's (1985, 1985b, 1969) logotherapy (the search for meaning) is considered an example of 'existential therapy') therapeutic schools, and while each is distinctive in terms of specific therapeutic discourse within the therapeutic encounter, all three approaches typically subscribe to primary meta-theoretical principles. That is, all place natural biology at the discursive center since it is believed that people have a natural, innate, biologically programmed self (organic self) which gives rise to 'authentic (emotional) experience'; conversely, the constraints of social discourse alienate or limit legitimate, authentic emotional experience since 'false' or 'unauthentic selves' emerge in efforts to ensure social acceptance within moral order at a social-collective level - any resulting disjunction may precipitate psychopathology. Psychotherapy therefore endeavors to repair any disjunction between the organic (true) and the social (false) selves through bringing about greater congruence between the two levels of being by assisting individual clients in individual and group therapy processes.

Client-centered approaches attempt to create greater 'congruence' or personal 'growth' through 'feeling reflections' (speech-acts), an attitude of 'non-possessive warmth' and 'empathetic listening',

'unconditional positive regard' (non-judgement) and 'therapist congruence' in relation to thoughts and feelings about the 'therapeutic encounter' and typically involves one client working together with a single therapist. In this manner, emanations from the hypothesized 'organic self' can be highlighted over time, and given sustained psychotherapy - so the theory goes - the client will formulate alternative, more personally agreeable emotionalized attitudes for themselves.

Gestalt approaches, on the other hand, attempt to facilitate greater personal congruence by emphasizing the unity of mind and body, and by placing strong emphasis on the integration of thought, feeling and action by clients as they are assisted in completing 'gestalten' during psychotherapy; that is, integrating detached, disconnected or discarded emotional experiences (story-lines) which are believed to be trapped within the body as a function of 'unfinished business' given the ongoing demands and conflicts implicit within any life circumstances. This can be achieved through group or individual therapy processes where a specific form of dream analysis can occur, for example, as well as role play, artistic activities and other self expressive procedures, and informs efforts to bring about self-awareness and self-acceptance within the individual person as they pursue ever higher levels of self integration.

Existential therapy does not have a defined set of therapeutic procedures and techniques but rather emphasizes the uniqueness of each individual and their way of 'being-in-the-world'. Clients are challenged into bringing about greater personal congruence (authentic experience) through questioning by the therapist as to the meaning and purpose of their own existence, and by highlighting the pivotal position of personal choice, responsibility and self-directedness within these efforts. Furthermore, authenticity within the therapist-client encounter (e.g., the therapist self-discloses personal information) also facilitates the development of 'authentic being-in-the-world' for the client.

Humanistic-phenomenologic meta-theory therefore de-emphasizes any discursive construction outside of the client's perceptions and therefore client-centered, gestalt and existential schools of thought can be usefully integrated into Discursive Psychology meta-theory which also places the volitional subject; that is, the independent discursive agent, at the epicenter of meta-theory and it too can be subsumed within the humanistic-phenomenological paradigm. However, the Discursive Psychology position within this broad meta-theory also integrates Empirical elements and elaborates upon the post-modernist themes immanent within existential ideas yet still preserves a Realist understanding of affectivity as well as the centrality of individual responsibility, choice and self-construction within collectives (self identity). Discursive Psychology therefore subsumes humanistic-phenomenological therapeutic approaches since at a meta-theoretical level both positions are

philosophically isomorphic, yet the former redresses the conceptual limitations of the latter by further reconciling 'Empiricism' and 'collectivity' within the human centered discursive universe of therapeutic phenomenology. As such, the theoretical strengths of Positivism (the discursive past) can be integrated with the collectively orientated, Social Constructionist paradigm which has informed more recent movements in contemporary psychotherapy - *systems-theoretical, narrative* and *deconstruction analysis* therapeutic approaches as these have emerged historically. We turn firstly to a meta-theoretical discussion of the systems-theoretical position before moving on sequentially to philosophical analysis of the other two Social Constructionist therapeutic positions in relation to the meta-theoretical contentions under investigation.

**The Systems-theoretical Story-line**

Although Social Constructionist notions are foregrounded in systems-theoretical psychotherapeutic approaches and comprise a radical epistemological shift from Positivist meta-theory already discussed, some systemic schools incorporate important Realist elements; that is, the various systemic approaches, namely, *strategic, structural, Milanese* and *eco-systemic*, differ as to their positioning between the two epistemological poles, some incorporating important Realist theoretical elements within their formulations, while others move towards a radical Social Constructionist position, deliberately bleeding out any Realist affiliation. It is posited for this doctoral thesis that indeed systems-theoretical schools have important relevancy for the fine balancing of *both* Positivist and Social Constructionist epistemological elements within one overarching psychotherapeutic meta-theoretical formulation which is necessary in order to harness the therapeutic strengths of all the different psychotherapeutic schools of thought. The pitfalls of both philosophical perspectives can be redressed by the other if their mutual conceptual compatibility can be demonstrated meta-theoretically as well as theoretically and practically. Unfortunately the systems-theoretical cluster of psychotherapies tend to lose focus on the individual-private, or intrapsychic level and understand all psychopathology to arise as a function of faulty communication within collectivity. So too are biological factors distanced in their meta-theorizing since social communication is placed at the center of the systemic epistemology. On the other hand, the position of emotional factors in the systemic formula points towards meta-theoretical compatibility with Discursive Psychology where, for example, symptoms pertaining to 'mood disorders' (e.g., Major Depression) are considered discursive signals within interpersonal interaction although contrary to Discursive Psychology, intrapsychic explanations are dropped entirely from the formulation. Systems-theoretical therapeutic schools therefore place cognitive aspects at the epicenter of their philosophical substratum through the emphasis on 'talk' and therefore can be easily assimilated into discursive therapy, especially as each school provides useful therapeutic concepts and techniques for working with collectives and indeed can also be adapted for therapeutic work with individuals.

Historically, Haley's (1963) *strategic* school was the first to emerge in a long succession of systems-theoretical strategic techniques, principles and strategies for application during therapy in an effort to shift 'faulty communication' patterns within collectives, for example, family systems or married couples, although it is possible to work 'strategically' with individual patients as well . That is, 'psychopathological symptoms' are typically understood to be socially constructed for the most part, through the discursive interaction of people within groups (recursive, synergistic feedback loops). For example, symptoms typical of 'Major Depression' might be conceptualized rather as a 'relationship metaphor' within family or marital relationships; that is, a symptomatic child might control parental attention, or a domineering spouse might be counter controlled by their depressive partner through the patient role and, of course, the attendant social discourse or 'talk' pertaining to this discursive positioning. The emphasis of these early systemic schools is mostly on power relations within interpersonal systems, where symptomatic communication positioned powerful others as helpless, for example, since being so-called 'out of control' or 'mentally ill' was, conversely, being 'in control' for the 'index patient'. These theoretical formulations hatched a range of paradoxical techniques (strategic discursive tools) for effecting repositioning of discourse so to restructure 'faulty communication' between interlocutors and laid the foundation for the first wave of systems-theoretical schools with a Realist stance; that is, notions of 'relationship pathology', 'faulty communication' etc. simply inflated 'the patient' as entity to a social-collective unit. Therapeutic treatment therefore focused on interpersonal rather than individual units and the strategic therapist attempted to correct 'faulty communication' using a formulated collection of mechanistic principles and clever tactics for initiating therapeutic change towards psychological health in the 'index patient' by intervening at the collective level.

Similarly, Minuchin's (1974) *structural* model also reflects central Realist elements since family subsystems (e.g., spousal, parental, sibling) are understood to be real entities. Furthermore, psychopathology is deemed to exist given an identified list of possible relationship boundary anomalies, where, for instance, estranged spouses are deliberately positioned together by a child through discourse (including behavior) associated with eating disorders, for example. Therapeutic attention is focused therefore on restructuring subsystem boundaries through family or couples therapy, for example, so that 'faulty communication' can be remedied. The structural systems model is therefore Social Constructionist in orientation and relies on the operation of social discourse or 'talk' in the construction of subsystem boundaries and is therefore epistemologically compatible with Discursive Psychology meta-theory in these regards. However, Minuchin subscribes to a normative model for 'ideal family' functioning which is clearly Realist at a meta-theoretical level - the criticisms leveled at Positivist psychotherapeutic positions (i.e., ethnocentric, mechanistic re-

description) can also, therefore, be directed towards both strategic and structural systemic models, while outcomes-based Empirical focus (relieving psychiatric symptoms) resonates their strengths as both therapeutic models and in terms of their meta-theoretical positioning for the discursive clinical psychology project.

In order to purge these early hybrid Social Constructionist models of their Realist leanings, a second wave of systems-theoretical therapeutic positions emerged with a distinctly Social Constructionist orientation, where indeed theoreticians attempted to formulate wholly Social Constructionist therapeutic meta-theory, theory and practice in order to systematize their epistemological allegiance. The Milanese (Selvini, Boscolo, Cecchin & Prata, 1978, 1980) systems-theoretical school is typical of this wave of theorizing in Clinical Psychology; that is, a group of therapists typically perform a facilitative role within collective units (usually families) through stimulating communication sequences between individual members of the collective using various techniques (e.g., circular questioning, perturbing). Psychopathological labeling is avoided where possible although their efforts are ironically usually a function of clinical directives; that is, Milanese therapists attempt to refrain from any discursive imposition onto the systems under their treatment - 'therapeutic neutrality' is attempted since any therapeutic position is necessarily biased and socially constructed, so the radical Social Constructionist position reads. Consequently three or more psychotherapists are used during family therapy, for example, in order to maintain Social Constructionist epistemological validity and not contaminate the system through the narrowness of one therapeutic point of view and, conversely, to ensure that any therapist is not positioned by the idiosyncratic discursive practices of the system under treatment.

Needless to say, the Milanese approach attempts to address certain serious epistemological concerns in psychotherapy yet its overarching meta-theory is not fully reconcilable with implications for practical psychotherapy. By theoretical implication, therefore, a crucial meta-theoretical question appears to require answering, that is, whether a radical Social Constructionist meta-theoretical position is indeed *possible* for Clinical Psychology at all since by *definition* the discipline is allied to the staunchly Positivist psychiatric model? Conversely, the mental health fraternity might reformulate its fundamental assumptions so to accommodate a purist Social Constructionist mental health position. While there is no correct answer to these epistemological questions, it is necessary for any psychotherapeutic practitioner to choose one or other philosophical position and indeed some of the more radical family therapists lobby persistently for the latter choice within psychiatric circles, where, for example, they maintain that problem identification and treatment should occur within democratic negotiation processes between client and service provider (Gergen, Hoffman & Anderson, 1996). In addressing this unavoidable epistemological choice, discursive clinical psychology chooses

to integrate the meta-theoretical strengths of both Positivism and Social Constructionism by discarding any radical positioning between the twin pillars of modernity, preferring to tread a middle path and thereby enjoying the discursive fruits (i.e., therapeutic tools as rhetorical positioning devices within therapeutic discourse) of both therapeutic traditions.

The eco-systemic (Barker, 1965; Barker & Associates, 1978; Anderson & Carter, 1978; Bronfenbrenner, 1975; 1979) systems-theoretical school was the last to emerge of the collective approaches and attempted to integrate the strengths of the forgoing systemic interventions with cultural relativism, and therefore integrates both Positivist and Social Constructionist elements within its theoretical framework. This was typically achieved by developing notions of 'systemic levels' and include a host of possible models punctuating the wider human ecology or discursive universe. Bronfenbrenner's ecological model is typical of this theoretical trend and includes a microsystem (discursive activity context containing an individual, e.g., the classroom), mesosystem (the relation of one microsystem to another (e.g., home and school)), exosystem (discursive contexts which the individual does not enter directly but which nevertheless influence lower order systemic levels (e.g., parents' work place) and, finally, the macrosystem which comprises the overarching cultural discourse informing discursive practices within the lower order systemic levels. In this psychotherapeutic formulation, clinical symptoms are considered features of systemic incongruence or stress between systemic levels, for example, a child might develop behavioral problems at school given overworked professional parents. Therapeutic intervention therefore attempts to bring about 'congruence' between systemic levels which might include discursive restructuring within microsystems (e.g., parents spending more family time at home), at the meso-and exo- systemic levels (e.g., engaging a child in the parental workplace), and in terms of broader macrosystems (e.g., parents relocating to a rural community). These interventions are informed by an overarching therapeutic principle based on eco-systemic theoretical assumptions pertaining to ontological development; that is, an ever increasing range of exosystemic discursive contexts become part of the growing individual's mesosystem - in this manner, psychological growth is understood to occur both naturally and through psychotherapy.

The notion of a broad discursive universe punctuated by systemic levels is certainly useful for the discursive clinical psychologist and provides a broad, practical model upon which to structure discursive therapeutic interventions. Furthermore, the school is sympathetic to more Empirical forms of inquiry in its efforts to liberate the latent developmental potentials hidden within the human eco-system. Furthermore, eco-systemic models are based upon Realist assumptions supporting notions of specified discursive contexts with distinctive discursive practices while still supporting cultural plurality and Social Constructionist ideas more generally. However, as in all theorizing, the eco-

systemic formulation is also limited in that it tends to ignore biological and intrapsychic factors, and therefore does not deal with thinking and emotion as experienced by the individual, focusing rather on environmental potentials; indeed the individual's position more generally speaking is marginalized within the multiple, powerful social discourses which are placed at the theoretical center of this systems-theoretical formulation - it is criticisms such as these which have encouraged narrative therapists to place the individual agent at the epicenter of their Social Constructionist position.

**The Narrative Therapy Story-line**

Epston, White & Murray (1992) focus on 're-authoring life stories' which position people unfavorably in discourse by encouraging the performance of deliberate acts of 'agency'; that is, discursive control of social discourse by the individual. People seeking improved life adjustment and solutions to life problems may be assisted by the therapist's facilitation of discussion pertaining to their life problems, as perceived principally by the client (McNamee & Gergen, 1992; Sarbin, 1986). Thereafter, attempts to assist clients in rewriting their 'stories' in more agreeable ways (as defined by the client) are made during therapeutic positioning. For example, an adult 'incest survivor' experiencing sexual difficulties in her marriage might be encouraged by her therapist to amplify coping resources already developed and used, thereby presenting the client with alternative discursive options pertaining to personal control; that is, the client's 'story' might involve discursive assumptions absorbed historically and/or through contemporary social discourse (including literature) that early sexual trauma will *inevitably* lead to adult sexual dysfunction - by creating an alternative, more personally empowering kind of therapeutic talk, the narrative therapist encourages the development of personal agency (O' Hanlon & Weiner-Davis, 1988; O' Hanlon, 1992). Narrative therapy is often brief and solution focused (de Shazer, 1985). In this manner, the individual is provided a greater range of discursive control for dealing more effectively with life problems since they experience themselves as the director of their own discursive positioning rather than being forceably positioned by the 'stories' themselves.

Narrative therapists typically use therapeutic and epistemological metaphors akin to the Milanese and other radical Social Constructionist schools of psychotherapy, and therefore maintain a focused self reflexive vigilance against discursive imposition during therapeutic talk - consequently, the meta-theoretical reservations leveled at the Milanese position (see above) can also be directed at narrative therapy. Clearly cognition (discourse) is centrally placed while emotion is simultaneously integrated with discourse more generally as a formal unity. Biological factors are considered only in terms of the client's story and do not comprise any clinical formulation or treatment intervention given the position's radical Social Constructionist meta-theoretical leanings and concerted efforts to bleed out any Realist contagion. Furthermore, by placing individual agency at the epicenter of this formulation,

the coercive power of social discourse is relegated a marginal position as are collective processes which necessarily limit the meta-theoretical range of this form of psychotherapy.

**The Therapeutic Deconstruction Analysis Story-line**

Therapeutic deconstruction analysis emerged from the academic deconstruction movement which is fundamentally Social Constructionist in orientation and frames as its subject matter all social discourses, therapeutic and other, within its critical gaze (Gergen, 1991, 1982, 1971; Gilligan, 1982). Essentially deconstructionists retrace the theoretical roots of any formalized discourse to the socio-historical discursive trends which constitute first principles for the position under investigation. Deconstruction analysis is typically focused on the political positioning of various discourses as these are legitimated through social power of influential groups in any given society. For example, developmental psychology theory might be deconstructed in terms of 'technocratic' social order (story-line), for example, where 'developmental stages and goals' are formulated as a function of the 'mechanistic', 'stage progressive' and 'productivity' oriented first premises contained within capitalist discursive practices (Burman, 1994). Similarly, notions such as 'psychopathology' have been deconstructed by Parker, Georgia CA, Harper, McLaughlin & Stowell-Smith (1995) in order to reveal the implicit power relations within the psychiatric story-line, for example, and posit alternatives. The authors offer a functionalist deconstruction orientation for psychotherapy which involves indepth analysis of the coercive force of various discourses as these affect individuals and groups of people and the social institutions of which they are a part.

Therapeutic deconstruction analysis is typically conducted in research or discussion forums (Levett, Cottler, Burman & Parker, 1997) as well as therapeutic contexts (Parker et al., 1995), where people experiencing life problems are provided an opportunity to gain both insight into their implicit societal positioning through power relations (e.g., 'racist' or 'gender' related issues, or people positioned as 'psychiatric patients') and then encouraged to 're-author' their discursive positioning in a manner more agreeable to the individual subjects' themselves. For example, Parker et al. discuss therapeutic forums for people with schizophrenic symptoms where individuals are encouraged to learn from 'the voices' and not dismiss them simply as 'auditory hallucinations' or resort to psychiatric positioning.

Therapeutic deconstruction analysis is still in its infancy as a treatment modality and therefore still remains to be more fully developed by proponents of the approach, however, at a meta-theoretical level, therapeutic deconstruction analysis retains all the strengths and weaknesses of the radical Social Constructionsit therapeutic schools (see above). Furthermore, the emphasis on political factors at the social-collective level provides an important permutation to re-authoring strategies during therapeutic efforts, on the one hand, yet an all encompassing preoccupation and therapeutic focus on

social power issues may blind therapists and clients alike to other discursive potentials in their efforts to create a meaningful position for themselves within the natural limits of their discursive universes.

## CONCLUSION

This thesis attempts to introduce an overarching meta-theory (Discursive Psychology, as espoused by Rom Harré) as a clinical 'toolkit' for therapeutic psychology which harnesses the strengths and mitigates the theoretical and practical weaknesses of the various schools of therapeutic psychology which have emerged as a function of both Positivist and Social Constructionist epistemologies over the last century in the Western world. Discursive Psychology epistemology is important since Harré's formulation is most useful when confronting complex social situations comprising individuals within collectives, and where careful dissection of both intra- and inter- personal psychological space are central concerns - indeed, the psychological treatment of people by a trained clinician during psychotherapy appears to be one such complex social situation. A conceptual meta-theory and practical methodology based on Harré's philosophical schema which allows the useful synthesis of diverse therapeutic 'tools' from various psychotherapeutic traditions, may therefore be extremely useful in organizing, orientating and directing clinical diagnosis, formulation and therapeutic positioning during the course of clinical work.

In order to achieve this goal, it is necessary to firstly outline the details of Rom Harré's meta-theory for (social) psychology in some detail in Chapters 2 and 3, before moving on to a discussion of theoretically compatible research instruments in Chapter 4, while Chapter 5 concludes Part I (theoretical orientation) of this thesis by demonstrating these meta-theoretical formulations in terms of theoretical and practical application to psychotherapy and the broad enterprise of Clinical Psychology. Part II (illustrative empirical research) includes three clinical case studies and are discussed in Chapters 6-9, before critically reviewing the discursive clinical psychology project as a whole and concluding in Chapter 10.

Chapter 2

# Harré's Discursive Psychology: Heritage, Meta-theory and Theoretical Development

Rom Harré, philosopher, theoretician and academic, has contributed enormously to the field of theoretical psychology for over a quarter of a century. During this time, academics have used words such as "psycho-heresy" (Wren, 1987) and "revolutionary" (Bhaskar, 1990) in connection with his thought since his theoretical assertions and philosophical positions have leveled penetrating criticism at the hegemonic Positivist paradigm, changing perhaps forever the way that some scientists in both the physical and social sciences would view themselves. Indeed his powerful influence is apparent from works such as "*Harré and his Critics: essays in honour of Rom Harré with his commentary on them*", a compilation of essays traversing topics typically distanced one from another - deep philosophy of science and dialectics, physics, primate behaviour and ethology, clinical psychology and psychiatry, communication theory and social constructionism, and micro-sociology.

Although his criticisms pertaining to psychology have focused mainly on social psychology, the meta-theoretical implications of these insights have generated considerable debate about the nature of scientific investigation in the social sciences more generally (Gergen, 1991, 1982, 1971; Bhaskar, 1993, 1990) and thereby have drawn interest and concern in applied Clinical Psychology (Hoffman, 1992; Epston, White and Murray, 1992). In order to understand the context of the vast contribution made by Harré, and its implications for this dissertation, it is necessary to trace briefly, first, his biographical background and the intellectual ethos which marked his heritage, and, second, the nature of the epistemological context of the academic worlds in which he found himself immersed and challenged, which together formed the impetus for his metaphysical project in psychology. Thereafter we review the evolution of his new paradigm for social psychology, from the early formulations of the 1970s through to his later, more mature work of the 1990s, both in terms of theory and meta-theory. Extensive quotes have been used directly from Harré's writings in order to preserve the sense of both the authenticity of Harré's voice as well as the immediacy of his difficult philosophical journey into the unknown territory of discursive metaphysics and its implications.

## BIOGRAPHICAL SKETCH

In his introductory remarks about Rom Harré, the influential Realist philosopher, Roy Bhaskar, a long standing colleague and personal friend of Rom's, briefly informs the reader of the following biographical details (Bhaskar, 1990). Harré was born in Apti, New Zealand on the 18 December

1927. He initially taught Applied Mathematics and Physics at King's College, Auckland and, at the age of twenty-five, he and his wife Hettie Harré set forth for Oxford, England. In June 1956 he obtained his B.Phil. in Philosophy. He then spent a year as a Research Fellow in Birmingham University and three years as a Lecturer at Leicester, before returning to Oxford as University Lecturer in Philosophy of Science. He was a founder member of Linacre College, Oxford in 1962 where he remains a Fellow. He is concurrently also Professor of Psychology at Georgetown University, Washington DC.

Bhaskar mentions that

> *"Rom has spent a part of each vacation since the late 1960s writing at Casa Harré in Alicante, Spain (and has) ...been a prolific writer, a dedicated and inspiring teacher and a tireless and resourceful peripatetic lecturer over the years." (p.1)*

His first book publication, *"Brief Introduction to Symbolic Logic"* has been followed by well over forty books which he has authored, co-authored, edited or co-edited.

Although Harré's interests range across divergent disciplines, Bhaskar maintains that his essential contribution pertains to two primary areas of concern:

1) *"(D)efending and developing a realist approach to science"*;
2) *"(T)he strand explicating the philosophical foundations and presuppositions of {social} psychology"* ( p. 1).

Moreover, Bhaskar maintains that

> *"(i)f there is a common factor present in all Rom's work it must be his passion for knowledge and, in particular, scientific knowledge; and, more generally, his enthusiasm for that grand conversation which on his view, constitutes the stuff of social life. Rom is one of the world's collective workers and many of the contributors to this Festschrift have collaborated with him on joint projects"* (p. 2).

We turn now to consider therefore the theoretical beginnings and development of this second strand of the "grand *conversation*" in order to contextualise and tease out the essential threads of Harré's thought pertinent to the concerns of this thesis.

**The Necessity for a New Paradigm in Psychology**

In a specially commissioned paper reviewing his work and the development of the so-called "new paradigm" over the twenty years prior to 1993, Harré (1993), reflecting in his own words, maintains that two main sources of discontent were overtly manifest during 1968, when he and Paul Secord began their discussions which culminated in the publication of their revolutionary book in 1972, "*The*

*Explanation of Social Behaviour"*, which marked the beginning of the development of the "new paradigm":

> *"One stemmed from the kind of language that social psychologists used in their published work: it was almost unreadable due to the use of a peculiar jargon to replace the subtle and sophisticated vocabulary of ordinary language. ... It was clear that it embodied an implicit and powerful metaphysical theory." ... " The second overt source of discontent was the restriction, rigorously enforced, that all empirical investigations were to conform to the format of laboratory "experiments". Worse, these "experiments" were, almost without exception, conducted in ways that excluded context. And worse still, the "results" were expressed numerically (and this required some heroic reworking of reality) and analysed statistically. It was clear that the very same blend of metaphysics and cultural ethnocentricity was implicit in the "experimental" methodology as one could recognize in the choice of vocabulary". (p.25)*

The Empiricist meta-theory involved two main principles which Harré believed made it especially unsuitable for scientific inquiry into the human social domain.

> *"The first had to do with how what people did should be construed. The use of intentional concepts, such as "helping", requires people to be taken to be agents engaging in purposeful action. These concepts were excluded from the "official" description of human behaviour in favour of non-intentional concepts, invented for the occasion. The use of this kind of concept, such as "helping behaviour", only makes sense if people are taken to be automata, merely reacting to environmental contingencies. This covert metaphysics effectively proscribed the use of concepts in social psychology that required explicit reference to local moral orders."*
>
> *"The second principle ... required the exclusion of time from social psychology ... (T)he use of abstract nouns like "aggression"... could only refer to abstract and timeless somethings. ... Projects for the study of the unfolding of typical episodes of social life simply could not be formulated, let alone actually carried out." (p.25)*

These philosophical blunders implicit within the social psychology of the 1960s, Harré (1993) asserts, were due to metaphysics; that is, the adoption of Logical Positivism as philosophical position. He suggests that this choice was made

> *"perhaps in the mistaken belief that it would guarantee a scientific status to their enterprise."* This he felt was a function of the *"American cultural idea of well trained and completely regulated behaviour according to pre-established schemes, expert manuals and*

*"officially" published procedures. According to that ideal, for every kind of interpersonal occasion there should be a routine way of accomplishing the project at hand". (p.25)*

As a foreigner working within the heritage of European thought and armed with a deep knowledge of the intricacies of Philosophy of Science, Harré (1993) writes,

*"Secord and I were able to stand back from our respective cultures, and to see the extent to which the whole enterprise of academic social psychology ... was the celebration of ethnocentricity. (p25)*

His exasperation at the metaphysical blindness of his colleagues seems keenly felt by Harré, and appears to be still present some twenty years later:

*"the dominance of the transatlantic paradigm based on the experimental investigation of individual automated "behaviour" was remarkable. To this day the Oxford University Department of Experimental Psychology has as a formal requirement that all empirical work should conform to the naïve experimental paradigm of the sixties". (p.25)*

It is possible to trace these epistemological assertions to a more general argument which is the hallmark of Harré's scientific discourse, linking together the typically divergent disciplines with which he grappled ; that is, a particular variety of Scientific Realism, developed in his capacity as philosopher of science, which undermined the omnipotent Humean theory (Harré, 1975) of causal laws (Harré & Stearns, 1995). Essentially this view questions the *deductivist* theory of scientific structure which asserts that the deductive system of laws is the core of a theory and that the mechanisms and associated picture of permanent objects within it are secondary to this core. Conversely Harré (1970) claimed that this view comprised a philosophical error and, turning this formulation on its head, suggested that indeed it was the *explanatory model* which formed the essence of a theory, while the deductive system within it represented the secondary heuristic content. Moving deeper into the implications of this revolutionary view, Harré insisted that the model itself designated something real, forming the mechanism generating the phenomena while simultaneously being imposed upon the phenomena by man. Consequently it is possible to view scientific progress as occurring by means of a dialectic where possible models are checked out for their plausibility, which in turn become the phenomena to be explained; this process might continue without end. The fine balancing of Idealism on the one hand and Realism on the other, provides an epistemological strength which Bhaskar (1990) describes as

*"a kind of rootedness in the phenomena of the day, which a realism of greater metaphysical consistency might well lack"* (p. 9).

Harré (1990) expresses this tension in his distinction between *convergent* and *policy Realism:* the former refers to the converging perceptions of the observer and the material world, while the latter involves the constructed scientific object and the filtering properties of the metaphysical choices made by the scientific observer - thus a synthesis of a weaker, qualified form of *materialism* on the one hand, and a stronger, undiluted form of *Idealism* on the other, emerge within this view. Consequently Harré (1990) observes:

> *"(B)efore the proposition is the "scientific act", a purposeful intervention in a natural system, guided by theory and assessed by reference to criteria of practical success or failure" (p. 303).* Further, *"the current properties of the world, the "total" world, which ground the dispositions we ascribe as affordances, can never become available to us independently of the apparatus that we have the ingenuity and the technical skills to construct. "The limitations of my equipment are the limitations of my world"" (p. 302).*

These notions suggest, further, the necessity for Harré to assimilate Wittgenstein's (1953) emphasis on the limitations of the discursive grammars which comprise our scientific and other human endeavours within this meta-theory; language becomes the *ubiquitous* apparatus which limits the human world. Similarly, it is the limitations set by human physicality which comprise the real limits of ones position in the world of things and others. Hence Harré's (1990) dictum:

> *"so far as anyone has ever been able to ascertain there are only two human realities: physiology and discourse (conversation) - the former an individual phenomenon, the latter collective'* (p. 345).

In summary, it is possible to identify the following primary assertions below. Harré (1990) believes that these characterize *"the only sustainable variety of realism"* (p. 350) for the Physical Sciences (A), and Social and Psychological Study (B), respectively. Not only does each ontology represent a metaphysical cognate to the other, but, most importantly, the former is comprehended under the latter:

> *(A)*
>
> 1. *"There is a world, which exists independently of human beings. It is at best partially available to us as an object for portrayal and manipulation, that is, as an Umwelt.*
> 2. *In the ultimate stages of the hierarchical development of the physical sciences we have passed beyond what is available to us via ... 'direct perception' to the affordances of that World*
> 3. *We know that these are the affordances of an independent reality because the objects in our human umwelten are only so far malleable to human manipulation".*

*(B)*

*1. There is a species-wide and history-long Conversation, only partially available to individual human beings, as their social Umwelten. But these Umwelten are structured for each of us by local moral orders, that is, by tacitly accepted systems of rights, duties and obligations, fixing the roles of contributors to this or that conversation.*

*2. In the ultimate stage of the development of the reflexive study of human life we pass beyond the investigation of those language games which are transparent to any one of us, to the open set of possibilities that are the affordances of the Conversation.*

*3. The Conversation is only* ***so far*** (Harré's emphasis) *amenable to the influence of individual speakers." (p 351)*

The primary tension between Scientific Realism and Social Constructionism characterizes the essence of the metaphysical relevance of Harré's academic project for the social sciences. While the Logical Positivist paradigm in psychology continues in many sub-disciplines of the field, including applied clinical approaches in the form of behaviourism, for example, the emergence of a huge range of radical Social Constructionist clinical approaches (McNamee & Gergen, 1992) has presented its own set of problems all essentially located in the lack of rootedness in the material stuff of everyday life. In this regard Efran & Clarfield (1992) maintain that

> *"...it is hard to avoid sympathizing with those bewildered souls on the professional firing lines who feel the need for more concrete instructions, particularly from those implying that they have been heading in the wrong direction. Clinicians need to know how constructivism might help them deal more effectively with a quarreling couple, a cocaine-addicted teenager, a suicidal husband, a house-bound agoraphobic, an obsessive hand-washer, or a high school drop"* (p 215).

By creating a middle way between the twin dangers of the metaphysical blindness of hard, Empiricist theories of self on the one hand, and the vagaries and potential solipsism of Social Constructionist orientated approaches on the other, this critical tension comprises the principal reason for choosing Harré's thought for the development of a clinical meta-model for working with life problems that people bring to the clinical context for solving. We consider now the historical development and refinement of the new paradigm.

**The Search for a New Paradigm: Trial and Error**

In order to formalize these metaphysical assumptions into a coherent working model for social psychology, Harré, during the late 1960s and early 1970s, turned to various theorists and researchers from diverse disciplines in his search for philosophically adequate material. Principal amongst these

were Goffman (1969) who did pioneering work in the field of micro-sociology, Garfinkel, (1967) for his contributions in ethnography, and Lorentz, Tinbergen and Goodall (Harré, 1993) who had undertaken a similar project in connection with ethological studies. The latter discipline was central to the new paradigm development since it drew on methodology inspired by the study of animal behavior as it occurred in the natural settings inhabited by animals themselves, and not artificial laboratory contexts. Consequently Harré & Secord (1972) developed the term *"ethogenics"*, an early epithet representing the paradigm shift in social psychology. In this regard, Harré (1993) writes:

> *" The great ethologists took their keen eyes and their open notebooks into the real world in which birds, beasts and beetles lived their daily lives. They kept meticulous records of how wasps lived, what sticklebacks did in the mating season, which birds sing at which times, what chimpanzees do to change and maintain their social hierarchies , and so on. (We) ... chose to call our proposed new paradigm "ethogenics" in part as a direct reference to the work of the ethologists, which we saw as having made exactly the break with experimentation that we advocated for social psychology" (p.26).*

During the early 1970s, Garfinkel and Goffman, emerging from outside of mainstream academic social psychology, did much to influence his early structural model, ethogenics, since they too considered metaphysics crucial to their scientific enterprise. Garfinkel's ethnomethodology relied on the notion that *rules*, which expressed the practical knowledge required for skilled action in any circumscribed social context, formed the unit of analysis for an epistemologically sound ethnography. Similarly, Goffman's analytical analogue, the *dramaturgical* model involving the notion of *moral careers,* in which he compared the many activities of everyday life to theatrical performances - thus a doctor's surgery may be compared to a stage setting, while the doctors, staff and patients may seen as the players - also informed the fulfillment of a number of crucial metaphysical criteria. That is,

> 1) *"Both Garfinkel and Goffman were concerned with the dynamics of a temporalised social psychology. Neither used the "experimental" method"*;
>
> 2) ***"Both had developed methodologies commensurate with the nature of the phenomena they were studying"*** (emphasised by Harré);
>
> 3) *"For both metaphysics drove the methodology"*;
>
> 4) *" For both the central idea of symbolic interactionism, that human life is created in the manipulation of symbols, and not in the automated responses to predefined situations, animated their research." (p.26)*

What impressed Harré and Secord most about these approaches, therefore, was their emphasis on the philosophical relatedness between the nature and content of what was being studied and the

methodologies and analytical models adopted for the investigation. In this sense, a truly human model informed their work as social scientists. Thus Harré tells us that

> *'The root metaphysical idea, which Secord and I called the* ***anthropomorphic model*** (Harré's emphasis), *was that people had intentions, plans and projects and the skills to carry these projects jointly with others, according to the local conventions of propriety."*

Harré points out, however, that initially he and Secord made a number of crucial errors, which a closer reading of the implications of their initial model would have revealed. Firstly, the rule-sets which determined action involved an implicit causal notion and, secondly, were placed into people's heads. The first of these constituted a problem since rule-sets cannot be the causes of action which occurs within the complex flow of competing demands and inputs during everyday life; rule-sets can therefore only tell us if what we have done is responsible, acceptable, understandable and intelligible. Further, in order for coordinated social activity to occur at all, broader collectively held rule-sets should inform individual action; rule-sets cannot reside *within* individuals but must rather comprise the social discourses which *surround* individual agents/actors. Harré points to Wittgenstein in this regard who, much to Harré's apparent chagrin, had demonstrated these principles philosophically as early as 1953. Thirdly, Harré criticises his early formulations for being too rigid:

> *"What grounds have we for supposing that the plans and projects in which people are engaged in joint social action are universally the same? Why should we suppose that emotion repertoires are universal? What right do we have to assume that the forms of self dominant in post-industrial post-Christian Western ways of living are dominant everywhere and at all times?" (p. 26)*

Self critical reflexivity is present throughout Harré's discourse; he constantly revised and challenged his own assertions at different times, both as a function of the availability of new information and thought within the "*grand conversation*" and as his own empirical and philosophical investigations informed discoveries. Indeed he has been criticised ( Wren, 1987) for his tendency to assimilate other thinkers work and findings into his schema, often revising quite substantially his initial position, appearing 'fickle' at times. The self reflexive criticism of the rigidity of notions such as *rule-sets* and dramaturgical *roles*, a structuralist explanation (Swartz & Swartz, 1982), is a theme which becomes consistently stronger from the early 1970s, culminating eventually during the 1990s. Indeed this movement appears to be part of a deeper shifting away from the Realist-Positivist pole towards a more Social Constructionist perspective, while this movement itself reflects the broader shift in psychology generally; that is, the 'discursive turn' (Gergen, 1982), which had begun to emerge during the 1980s. This trend will however be explored in more detail towards the end of this chapter.

Despite these early blunders, after the publication of *Social Being (1979)*, Harré had managed to establish a clear position and theoretical schema for an anthropomorphic theory of human psychology. In this formulation, language and its socially constructive nature is centrally positioned since it accounts for the significant variations found within social environments, across cultures, yet also represents what is most universal to all human conditions, apart from their common physicality. In the second, revised edition of *Social Being* (1993b), Harré makes this abundantly clear:

> *"..., the attempt (is) to found a general psychology on the thesis that human psychology is best understood as coming into existence in the enormously variable discursive or symbolic interactions of persons, grounded in a common biological inheritance.*
>
> *We exist as persons for other people and for ourselves. As individuals we each have a social and a personal being. It is evident however that our individuality in each of these modes of being is bound up with the fact of embodiment. We are also physical beings, each in his or her own fleshly envelope" (p. 1).*

Harré formalized three sub-modes of being in the world, Ways-of-Being, upon these premises and claimed that psychology could be nothing but the study of the acquisition, maintenance and coordinated application of skills necessary to exist within the three mundane modes: social, personal and corporeal. He dedicated three books, each exploring a different mode of being in more detail, that is: S*ocial Being (1979; 1993b), Personal Being (1983) and Physical Being (1991)*. It is within this corpus of writings that we discover the essential formulations of the new paradigm. In addition, in a number of collaborative works with other researchers and academics as well as in assorted journal articles, Harré concentrated on, firstly, the development of Empirical methodology to test these formulations, e.g., "*Motives and Mechanisms*", and, secondly, on the pursuit of a developmental social psychology which would highlight and explain the acquisition of social skills and the development of personal and physical identity, e.g., "*Life Sentences*"; "*The Rules of Disorder*"; "*Conditions for a Social Psychology of Childhood*". It is important to note that up until the 1970s, developmental issues had not typically engaged social psychologists and therefore also marked groundbreaking work. However, a full discussion of developmental concerns will be reserved for in depth consideration in Chapter Three and a complete survey of Empirical rationale, methodology and methods will be undertaken in Chapter Four. The remaining pages of this chapter will focus on explicating the formulation of Ways-of-Being as espoused by Harré, as well as the important theoretical permutations and revisions identifiable during the 1990s.

## THE NEW PARADIGM: WAYS-OF-BEING

Harré (1983, pp. 44-45) identifies the following matrices which graphically summarize the structures and operation of the three mundane modes of being:

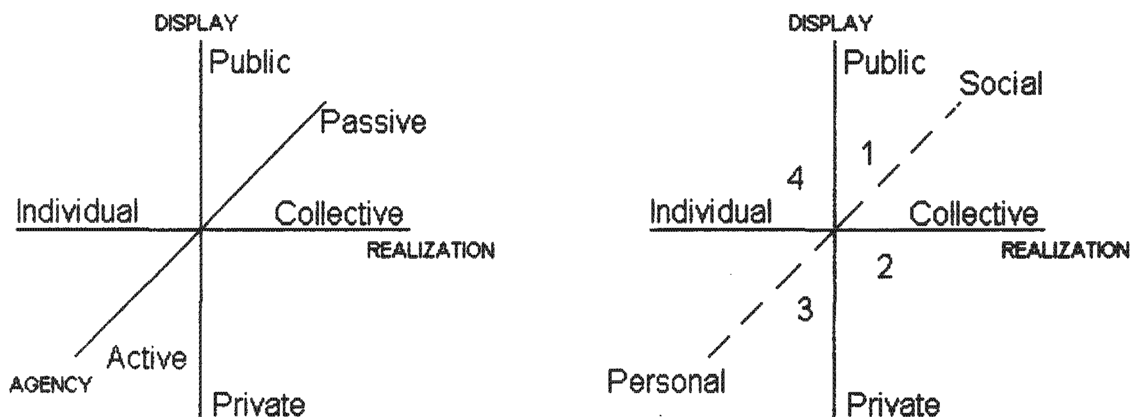


**Figure 1**

*Social-being* (Quadrant 1) is given a super-ordinate position within the trilogy since the social-collective dimension of being in the world is for Harré the most quintessential. It is from within our inherited social milieu that individuals are formed and given definition through the process of *psychological symbiosis*; that is, an established member of a specific discursive community provides the semiotic supports to nascent beings who, through their reciprocal efforts at becoming functional discursive participants within that context, incorporate the social order. Thus private-individual selves; that is, *personal -being* (Quadrant 3), emerge from within the discursive structures, roles and rhetoric inherent within the public-collective dimensions surrounding them. The developmental trajectory therefore emerges from quadrant one, clockwise through quadrants two, three and four, and, finally, back to quadrant one. Individuals are by necessity universally forced to evolve in this manner given the constraints of their corporeal, biological nature; that is, *physical being,* which in turn is defined and invested with meaning given the social proprieties pertinent to this or that form of embodiment - man or woman, child or adult, and so on - specific to any interpersonal context. Individuals must therefore be positioned in some or other relation to a finite social discourse comprising pre-determined local rule-systems, beliefs and moral order, in terms of both their personal and physical identity.

In this sense, human individuals are passively constructed by their social contexts. However, as young humans grow and develop into active interlocutors within any one community which, on the grounds of supportive cross-cultural Empirical research, Harré (1974) maintains is biologically possible from the age of five years old, progressively increasing levels of personal autonomy and

agency are potentially exercised. This constitutes the active position within the developmental matrix. As responsible agents, individuals are able to select from, re-interpret, and actively re-formulate the possible rules of moral action. In this manner, individuals contribute and alter the social conditions which originally constituted them. Harré emphasizes the restrictive nature of the social universe, which represents the limits of all possible action open to individuals, while simultaneously allowing for the exercise of personal agency within these constraints. Human beings are therefore never free to act without constraint, despite personal agency. We review now each mode of being in more detail.

**Social Being**

Harré's formulations of the late 1970s and 1980s focus on three essential threads within the mode of *Social-being* (Harré, 1993b, 1979) :

1) *Speech-acts;*
2) *Moral order;*
3) *Emotionology.*

The first of these refers to the process whereby human action is regulated through sequences of hierarchically constituted, interactively functioning elements: that is, respectively, socially prescribed *speech-acts*, intended individual *actions* and specific *behavior*. These speech-acts are typically implicit as opposed to explicit; that is, *non-conscious*, to actors, vary cross-contextually and function both intra- and inter-personally. Speech-acts comprise specifiable *structures* involving *rule-systems*, designated social *roles*, and pre-determined *sequences* for sets of acts. Further, from the pioneering work of Saussure (1974) in applied linguistics, Harré adopts the notions of *illocutionary* and *perlocutionary* elements of discourse for the analysis of interpersonal action since through discourse, possibilities for action are both created and limited. While the locutionary aspect of discursive practice refers only to the semantic meaning of verbal interchanges between interlocutors, the illocutionary aspect of discursive practice refers to discursive value judgments between subjects. The perlocutionary aspects indicate the dimension of discursive episodes which result in determinate verbal or non-verbal actions for interlocutors. That is, in calling someone 'a silly idiot', an example of the illocutionary meaning, an actor is making a moral judgment of another during social discourse. The literal meaning of the words themselves, their locutionary aspect, is embedded within a deeper level of *social* discourse. A possible counter attack by the other represents the perlocutionary element since this involves an action as a direct result of a discursive episode within a social-moral framework. These Saussurean concepts articulate the important *relationship* dimension implicit within any ethogenic perspective.

Another important distinction involves the formal, contrasting categories: *expressive-moral* versus *practical* order. The latter pertains to constructed rules, beliefs and conventional modes for the material conditions of life which necessarily involves task performance or praxis, while the former refers to the socially defined possibilities for correct moral action under conditions of honour versus contempt. The expressive order subsumes the practical: moral reputation, Harré (1993b, 1979) maintains, eventually supersedes the practical necessities of life since it not only begins to define what practical necessity means but also becomes autonomous in its own right; most human activity is directed at the management of *moral careers*, not at day to day subsistence and survival within the material realities of life.

Similarly individuals bring their own style to the structured roles and speech-acts of the social contexts they inhabit. Thus by managing their personas or social-moral reputations in interpersonal contexts, individuals construct a moral character for themselves. In this sense 'personality' is not something which is distinctive to an individual but exists as a function of social contingencies. Moral orders might differ widely for one individual who may be an actor within a diverse range of moral orders; it is possible that these may even be contradictory, e.g., sexual attractiveness for women may mean having to be dependent and passive in their traditional female roles with men, while they may also simultaneously be expected to be assertive and aggressive in their roles as bosses with sub-ordinate male employees.

The rule-systems are themselves not available to all actors; some aspect of the moral order will always be hidden to an individual. The moral order exists beyond each of the individuals situated within that circumscribed social context, each individual has access to different aspects of the belief system which exists in an for itself, beyond specific actors. Ethogenic psychology distills the following components of the expressive order:

1. The distinct social setting (e.g. the workplace, school or family home);
2. The persona(s) presented within that situation (e.g. the assertive boss, the rebellious pupil, the caring mother);
3. The rule structure(s) for the occasion (e.g. implementing disciplinary procedures, refusing to conform to a dress code, staying at home to be with the children);
4. The arbiters of correct action within a particular situation (e.g. senior management, older rebellious pupils, experienced mothers).

In order to link together social and individual determinants of action, speech-acts and moral order must be explained in terms of the role of emotions, typically understood in traditional psychology (Harré, 1987) to arise within the individual. Specifically Harré uses the term "emotionology" to refer

to a specific set of socio-structural criteria for the *assessment* of the social proscription or acceptability of the performance of speech-acts, occurring at both the individual and collective level. This argues a Social Constructionist view of emotions since emotions are not simply "things" or nouns harbored within the individual but, rather, are *interpretations* of social events. These emotional assessments inform individual action within social contexts similarly to the way verbs inform action within the structural rules of the grammatically correct sentence; that is, verbs link the action of the subject to the object in a sentence, while emotions interpret the actions and reactions of the individual within collective contexts circumscribed by specified rule-systems and moral order. If, for example, an individual feels guilty, angry, happy or sad, and so on, these emotions must be understood as interpretations of the interpersonal interactions within the confines of social-moral order.

Emotions are therefore understood to vary considerably across social contexts; no form of emotional universalism is assumed, no basic emotions are believed to exist (Harré, 1983). Therefore the term "emotionology" refers to the contextually specific set of moral assessments which inform correct social action within a specific moral order. All emotionologies, however, comprise the following four components in principle (Harré, Clarke & De Carlo, 1985):

1. A characteristic bodily agitation which may have more than one emotion related to it;
2. Typical behavioral displays associated with some emotions;
3. Cognitive activity directed at finding and assigning a cause for one's arousal in order to determine the emotion one experiences;
4. A local moral order which involves both the differentiation of the emotions and the prescription of particular emotions on particular occasions (grief at funerals).

Not all emotions must include all four components. It is possible, however, to identify Wittgenstein's notion that specific conditions, including physiological arousal, warrant the application of a specific emotional *vocabulary* underlying these components. An ethogenic interpretation of the emotions, therefore, premises cognitive-linguistic aspects; physiological arousal, drive and motivation are understood to be instances of social, collective phenomena, and do not exist within individuals, so to speak, but rather originate and exist principally as a function of symbolic interpersonal communication mechanisms. Emotions may be experienced, therefore, by individuals as intrapsychic affects, phenomenologically speaking, and may even seem to occur as visceral sensations. Ethogenics, however, simply understands this to involve the individual-private dimension of being-in-the-world; that is, the relation of personal- and physical-being to individual connectedness with others. Emotions are therefore part of the inter-functional semiotic systems which comprise discursive relations. We turn now to consider the *individual's* experience of social-being in order to clarify this distinction.

**Personal Being**

In *"Personal Being: a Theory for Individual Psychology"* , Harré provides a sharp distinction between the concepts of "persons" and "selves": the former pertains to the socially defined, publicly visible being who is embodied, and capable of performing meaningful action of a public nature through endowments of various capacities and powers (Quadrant 1); the latter refers to the *individual's* sense of 'self', of singular inner being, or of personal unity self-conceived, at the private level (Quadrant 3). The 'self', a constructed entity, creates the unities of personal *identity, consciousness and agency*, the three principal aspects of personal-being. Each of these essential aspects will be discussed in detail below and, through this process, Harré's conception of the construction of selves, personal-being, will be demonstrated.

i) Self-identity is integrally interwoven from two main premises: *personal embodiment and recollection*. Both exist as a function of the natural, biological properties of the human being and both form the initial points in the otherwise social evolution of self. Personal embodiment as corporeal beings allows individuals as situated selves within moral order belief systems, to make reference to self in relation to other persons through the indexical pronoun and equivalent systems, which surrounding discursive fields make available. Action is therefore understood to be delimited by the fact of personal embodiment which constrains the individual's point of view and the extent of possible action. The developing nervous system is held responsible for this simply as a fact of its existence. However, the necessity and centrality of personal embodiment for the construction of selves can only makes sense in relation to recollection since through memories of inhabiting this or that position within the flow of situated conversation, the individual is able to formulate a personal identity as a function of his or her specified positional histories. Autobiographies are created through the acquisition of ways of making indexical reference to self and others. This process is facilitated through the previously discussed process of *psychological symbiosis*.

ii) Self-consciousness, which evolves from the initial prompting of innate neurological dispositions as *consciousness*, or sentient being, is further differentiated into the concepts of *propositional* and *self-attributable* consciousness. That is, propositional consciousness is knowing the content or objects of ones intentional thoughts, while self-attributable consciousness pertains to the *fact of* consciousness of the content and direction of thought; that is, the knowledge *that* one is self-aware and capable of deliberate intentional action. The former applies to the 'what' and the latter to the 'act' of consciousness per se. Both aspects of self-consciousness, however, are comprised essentially from the stuff of social discourse. Propositional consciousness exists as a function of the power to use indexical forms of expression with deliberate intent, while self-attributable consciousness is itself

regulated by the discursive practices present within the moral orders embedded within the social discursive fabric. The important implication of the socially differentiated properties of self-attributable consciousness is that not all societies or possible roles within social scripts provide the same forms, quality or quantity of self-attributable consciousness; this is a variable mediated through discursive relations. Indeed it is posited in this thesis, that discursive clinical psychology is one instance of moral-social activity where self awareness is the *principal* focus of concern.

iii) Personal agency is possible through the mutual inter-functioning of self-identity and -consciousness; that is, since individual selves are able to exist as identifiable individuals within collectives and be simultaneously self-reflexive in relation to their intentional activities within discursive relations, the self-directed agent is at the epi-centre of action and decision-making. A pure agent is free to choose between alternatives, formulate goal directed activity while forgoing distractions, temptations and short-term gratification in order to realize plans, and adopt new ways of thinking where necessary. Consequently personal agency is also integrally implicated with *moral responsibility*. Individual agents are free to create a character which is deemed morally acceptable within the confines of moral order through exercising free choice and monitoring their responsible action within a world of others.

It is important to note that the self is a location, not a substance or even an attribute. The sense of self is the sense of being located at a point in space, of having a perspective in time and having a variety of positions in local moral orders. It is not having the awareness of an entity at the core of one's being. Human beings become persons by acquiring a sense of self, which can only happen as a function of social being. Personal agency, an innate aspect of personal being, therefore evolves into moral responsibility within social being. Moreover, the nature, level and specific properties of personal agency is itself defined by the discursive content of specified social contexts and may vary considerably across, between and within discursive contexts. For example, in relation to men in patriarchal societies, children and women may be accorded very different levels of access to rights and privileges for exercising personal agency. Rather, their status might be socially determined as passive recipients of moral dictates and conditions, and not active participants and arbiters of proper moral action. Consequently discursive clinical psychology attempts to place the notion of personal agency at the center of any discursive investigation, thereby providing the optimum social affordance for the development of a sense of personal agency for the patient. In this way, individuals are given the opportunity to move out of the 'patient' role and into a more 'agential' way of being in relation to their life adjustment - indeed, patient-agent are dialogical opposites within the Clinical Psychology story-line.

Importantly, these forms of personal-being are not themselves considered transcendental; these may be altered both in their form and relation to one another. It is conceivable that collective concepts of self might inform personal- being in some societies, for instance; it is the fact of the *social forms* comprising personal-being in some or other form, given individual biology, which informs the overarching universal assumption of Harré's discursive theory of selves.

**Physical Being**

In "*Physical Being: a Theory for Corporeal Psychology*", Harré outlines the role of physiology within his meta-theory of Ways-of-Being. Locating physical-being in relation to the other two modes might be understood best through a graphic image involving three concentric circles: physical-being occupies the centre, personal-being the middle, and social-being the outer of the three levels. The entire image represents the whole range of human *Umwelten*. Social-being marks the most inclusive level, subsuming all other levels since it permeates through and is primarily responsible for the forms and structures of both personal- and physical-being. However, there is also an influence outwards from both lower order levels respectively; that is, the formulation of a self at the individual-private level, personal-being, allows for the creation of persons as moral agents at the collective-public level while the possibility for there being a social and personal way-of-being at all relies quintessentially upon the central axis of the bio-physiological realities of personal embodiment at the individual-corporeal level, the innermost zone. The reality of our fleshly envelopes, our bodies, unifies and gives definition to a human psychology of action; hence in Harré's ontology only ***physiology and discourse*** exist. Harré differentiates three aspects that inform how our bodies, their nature and condition enter into our everyday lives: *metaphysics, evaluations and semantics.*

The *metaphysical* demarcation is the most important of these constructs since the concepts of body and person can be interrelated in complex ways. That is, while corporeal personhood is bounded in space, enduring in time and sequential in its rhythms due to the fact of embodiment, bodies are themselves created into categories and characters through discursive operations. For example, wide hips and narrow shoulders represent an ideal body concept for womanhood, a person concept, while the reverse holds true for body concepts of manhood. When, however, we observe the vital statistics of real bodies both male and female, Harré points out that indeed a continuum exists with considerable overlap for polar body characteristics for individuals of either sex. Secondary sexual characteristics such as body hair as well as clothing, posture, gesture and carriage, all tertiary sexual characteristics, might emphasize either pole of sexual identity thereby defining the person characteristics of maleness or femaleness; this sharpening of gender categories is principally a function of social conventions. Similarly other body concepts such as tall-short, fat-thin and the like are polarized when in reality an even distribution exists across individuals. Indeed the lexical

structure of these socially constituted semantic pairs change through social history as a function of changing social conventions and discursive properties. That is, 'plumpness' may or may not be associated with fatness, while being 'slim' may allude to both ideal or less than ideal weight. Descriptive terms for body fat may also vary on the basis of body characteristics; that is, men may be 'thick-set' or 'obese', women 'buxom' or 'over-weight', or children 'healthy' or 'pudgy' depending on historical conceptions of proper body fat ratios current at the time.

Another important feature of the metaphysical relation between embodiment and personhood is that the experience of embodiment per se must always be represented according to available body concepts. 'Pain' or 'pleasure', somatic experiences such as 'tiredness' or 'exhilaration' and the like must necessarily be rendered symbolically through language. These symbolic renditions of body concepts might vary considerably from culture to culture, and epoch to epoch. The experience of embodiment is strongly biased in favor of the social grammars both at the individual-private level where self directed talk might occur, and at the public-social level where body states might be the object of conversation, consulting the doctor or indulging in the "How was it for you?" conversation with a lover, for example.

*Evaluations* on the other hand refer to the normative judgments, both public and private, involved in bodily form and function, where ethical sensibilities are sharpened by moral protection of the individual's material body as vehicle of personhood amongst others. The physical body is the object of a host of bodily rights and obligations pertaining to its treatment by individual people themselves as well as by others in the social worlds surrounding them. These rule-systems are always embedded in a moral order belief-system, and may vary even from situation to situation for one individual. These moral responsibilities may also pertain to the concept of illness and disease, for example, and not simply to restrictions on everyday bodily function. Indeed Harré claims that many admonitions about healthy living as well as disease warnings and signs of illness, can often be traced to little substantive physiological evidence. AIDS, for example, appears to function more as a means of controlling and managing the social expression of sexuality than actually indexing any empirically identifiable pathogen. Similarly, the very systems utilized to describe symptom patterns are themselves evaluations. For example, 'obesity' is a relative term depending on normative decisions about optimal levels of fatty deposits in different cultures, in different epochs for different individuals. Arguing along similar lines, the body may be actively cultivated according to social prescriptions of aesthetic beauty or sensuality current at the time. Japanese foot fetishism, involving the deliberate stunting of foot growth to create the highly desirable small feet in adult women, or modern-day body-building amongst both men and women, demonstrate how social evaluations of the body may direct its form and structure in ways quite unintended by nature. So too, as was argued

earlier, the physiological arousal usually identified with emotion concepts may be understood as part of a complex relation of sign systems informing moral assessments of action within specified moral order systems, dependent on a vocabulary of emotion words to contextualise their situated meaning within discursive relations. Once again it is important to note that physiological reactions, physiognomic displays as well as emotion words and their relative interpersonal meanings change both historically and contextually according to societal evaluations of moral order.

Corporeal *semantics* pertains to the meanings attributed to the human body; that is, as both signified and signifier. The Christian metaphor, for example, understands the blood and body of Christ to be signified by bread and wine during Eucharist ceremonies, as representations of redemption process concerning sin and moral disgrace, while hands poised in prayer might also be embedded in similar social discourse and signify holy communing with the godhead. The components of the human body are therefore biologically given although the meanings that can be attributed to each when used as gesture, sign or metaphor, are part of a deeper contextual discourse which supports physical-being in a world of others.

## POSITIONING VERSUS ROLES: THE SHARPENING OF PERSONAL AGENCY

Harré introduces the new, more flexible concept of social *'positioning' and 'positions'* during the 1990s (Harré & van Langenhove, 1999; Harré & Gillett, 1994; Harré & van Langenhove, 1992), as a revision of his earlier, more static notion of social 'structures', 'rules' and 'roles'. This is an important development since it indexes the movement away from the Realist (structural) interpretation of human action towards a more Social Constructionist argument in Harré's work. Indeed the work of this period appears to assimilate many of the post-modern and post-structural trends in social psychology which had been influenced by critical linguistics since the early 1970s (Burman, 1994; Shotter, 1993; Stainton-Rogers, 1992; Gergen, 1982). In particular Harré acknowledges the work of the feminist writer, Hollway (1984), who first utilized the term 'position' and 'positioning' in her analysis of the construction of subjectivity with regards to heterosexual relations although this notion had been part of formal marketing analysis (i.e., assessing the relation of one product to another, e.g., when launching a new magazine) for some time already (Harré, Brockmeier & Muhlhausler, 1999). Harré incorporates these ideas into his meta-theory which, it might be argued, provided the conceptual machinery he required to fully articulate his formulations concerning the active agent within social discourse.

Although this later formulation is essentially consistent and reconcilable with his original formulation in the three modes of being, it is however possible to identify the presence of subtle yet important

shifts in emphasis towards a more flexible formulation during the 1990s. In this ontology, Harré maintains a firm grasp on the real constraints of social discourse which exist within the confines of determinate social forces, yet merges the ethogenic emphasis on social *roles, acts, and rule-systems* with the notion of linguistically embedded *positions, speech-Acts/action, and story-lines*. This latter triad is the ontological basis upon which all 'positioning' efforts must be understood. Indeed, all discursive activity between interlocutors involves mutually defining sequences of the triad at a formal level; that is, the articulation of any 'position' by one interlocutor (X) relies on the presentation of certain 'speech-acts' in order to introduce alternative 'story-line/s' to interlocutor (Y). (Y) can choose to validate (X)'s position, refute or change it through reciprocal positioning efforts which necessarily involves the performance of certain speech-acts which, in turn, present possible story-lines, while the illocutionary or social force of a speech-act is itself reciprocally defined by both the story-line and the respective positioning choices; all aspects of this triad are therefore completely inter-functional. The perlocutionary elements in each reciprocal interchange *force* the emergence of ongoing discursive exchanges between conversants; these positions are *continuously* negotiated and re-negotiated in any conversation.

We witness therefore a turning away from both the early structural influences of Goffman's (1969) dramaturgical model and ideas borrowed from ethnomethodology, towards an explanation with a distinctly Social Constructionist, linguistic turn. The somewhat rigid notion of 'rule-systems' becomes synonymous with the more fluid construct of 'story-lines', while 'role' is almost entirely replaced by the notion of 'position'. *Rhetorical re-description*, that is, the use of story-lines to *explain* institutional activity and macro-social events which make them intelligible as societal icons (e.g., descriptions of mental hospitals as locales of healing rather than as efforts at social control), is an important related concept which indeed emerged considerably earlier in Harré's work (Harré, 1975). 'Rhetorical re-description' however, does not necessarily only involve people in conversation since it refers to *societal* icons as well, while any reference to 'positioning' always refers to interlocutors in relation to one another. We review now these new developments in some detail below.

**Varieties of Positioning**

A 'position' (Harré & van Langenhove, 1999; Harré & van Langenhove, 1992) within a conversation is a metaphorical concept through reference to which a person's moral and personal attributes as a speaker are meaningfully collected. A person may position themselves as powerful or powerless, confident or apologetic, dominant or submissive, certain or uncertain, etc.. This may even be in relation to a pre-existing moral order, although a 'position' can simply be identified with respect to these polarities of character; that is, role is to position what colour is to red or shape is to square.

Positioned as 'dependent', the same speech-acts would be construed in completely different terms to a person positioned as 'dominant'. These positions in turn are linked to story-lines, for example, a 'pedagogical' or 'radical feminist' story-line. Specified speech-acts would allow interlocutors within the conversation to both identify and adopt particular positions in relation to one another; conversely, speech-acts are also made intelligible through story-lines and various positions. Therefore, living out in one's speech and actions one of the 'pedagogical' story-lines involves adopting such and such a position, and at the same time it makes one's sayings and doings relatively determinate as social acts of instructions, correction, reprimand, congratulation and so on.

*First and second order positioning* refers to the level of rigidity and flexibility of moral position within a story-line. If a conversation occurs between a servant and master for example, a first order positioning is said to occur since the interpersonal maneuverings would usually be routine and undisputed. However, a wife or a friend treated as a servant through identifiable speech-acts might contest the illocutionary force of a verbal command; this would comprise a second order positioning ('talk about talk'). In addition, the former would constitute *performative positioning,* since speech-acts have perlocutionary force at this level, while any talk about talk, any challenge, revision or reflexive positioning on a conversation would be called *accountive positioning.* If this form of positioning occurs outside of the initial discussion, then this set of discursive practices would be classified as *third order* positioning, which may or may not involve persons other than the original participants. The therapeutic context, the clinician's position on everyday conversation, the therapeutic discourse and content, would be a typical instantiation of third order positioning.

*Moral positioning* refers to the roles that people occupy in relation to moral orders while *personal positioning* involves a more fluid, flexible notion of specific speech-acts in relation to an alternative story-line. An employee might explain *why* he is late, for example, while a boss might announce *that* he is late. Both forms of positioning are always present in positioning efforts. The more a person's actions cannot be made intelligible by reference to roles, the more prominent the personal positioning will be. In addition, and most importantly, every act of positioning inevitably positions *both the Self and Other/s,* although they are analytically distinctive terms. Any negotiation of new roles or positions must therefore be a collective activity. Further, any second or third order positioning would necessarily be *intentional*, while first order positioning is by definition *tacit* or implied. It is possible, however, that the two may occur simultaneously where first order positioning involves some form of lying or active manipulation.

Intentional positioning can be sub-divided into the following four distinct forms, all combinations of the varieties of positioning identified above:

1) *Situations of deliberate self-positioning*

e.g., - by stressing one's moral responsibility in connection with various choices, - expressing self-consciousness about ones actions, - referring to events in ones biography;

2) *Situations of forced self-positioning*

e.g., - accommodating to job criteria in an institution ;

3) *Situations of deliberate positioning of others*

e.g.,- when gossiping about a person, - deliberately creating a place for a person to respond in a story-line;

4) *Situations of forced positioning of others*

e.g., - a wife telling her husband to chastise their child, - the defendant in a court of law, - a resistant patient with a psychiatrist.

It is important to note a special case of (1) above, where self-positioning occurs at an *intra*-personal level in relation to the positions, speech-acts and story-lines told to by a person about themselves - an individual speaker can be both positioned and position themselves as might occur in collective positioning practices since the underlying mechanisms are very similar. Indeed, this is because Harré's meta-theory understands *private* acts of self-positioning to conform to *public* triadic structures. The pronoun indexicals, 'I' and 'me' (Muhlhausler & Harré, 1990), for example, as speech-acts position the self-reflexive speaker in obverse and reciprocal relation to each respective story-line and position available to the individual in his or her active creation of personal (as opposed to social) identity. Furthermore, in (3) above gossiping still involves the relation of *Self* to Other/s (not present) since any talk about another (e.g., negative evaluation) stands as a possible story-line for the person doing the gossiping. Finally, if in (4) above a person is positioned as insane by a court of law, for example; that is, deemed to lack personal agency or self-consciousness, then all previous positioning acts by legal authorities which would have made that person responsible for their actions would be rendered obsolete.

It is most important to recognize the following aspects about discursive positioning (Harré et al., 1999; Harré, 2000):

- the inherently *dynamic* character of positioning activity in social discourse - future structures within conversations can *never* be predicted, therefore. This is because both the story-line and illocutionary force of the speech-acts are *jointly* created by conversants, there is constant redefinition of the discursive elements through the story-line, speech-act and position triad.
- this taxonomy is culturally *contingent* since alternative social grammars from different moral orders may exclude the content of and therefore prescribe alternative positioning mechanisms. Harré however maintains that positioning theory is broad enough to have relevancy for a host of

endeavours such as in politics, marketing, assessment of technology or the study of intergroup conflict and relations. Included is *research* into the social sciences where the researcher both positions and is being positioned by their research subjects in the ways described above. Any research report should therefore reveal the 'story' of that research.

- individuals may differ in their *capacity* to position themselves or others since they lack the relevant *skills* and techniques of mastery. They also may simply be *unwilling* or lack the intention to position or be positioned.
- individuals may lack the *power* to be able to achieve positioning acts given their respective place within a moral order of rights, duties and obligations.
- it is possible for story-lines to be taken from both a cultural repertoire or *invented*; people differ in the cleverness of their narrative inventions.
- further differences may arise as a function of the story-line about positioning; that is, the coherency and effort involved in positioning activity itself relies on the extent of expected obligations and commitments to positioning practices.
- finally, interpersonal positioning efforts are also affected by *private,* intentional self-positioning. This means that intra-personal and inter-personal dimensions may interact in complex and dynamic ways which further enriches the ever emergent, unpredictable discursive practices which comprise the quintessence of what it means to be human.

## CONCLUSION

Rom Harré's Discursive Psychology treads a fine, articulate path between the respective pitfalls of Scientific Realism and Social Constructionism. His original criticism of social psychology has provided the generic discipline of psychology with a distinct, philosophically consistent meta-theory for the social sciences. This doctoral thesis attempts to apply this meta-theory, as well as its functional theoretical developments, to clinical work in psychology. With this goal in mind, we turn now to consider the implications of Harré's developmental theory and notions of psychological change in relation to Discursive Psychology.

Chapter 3

# Psychological Development and Change

Ethogenic psychology considers a broad range of genetic domains relevant to psychological development in human beings. Harré (1983, p. 258) identifies critical transitional nodes in his meta-theory, each informing distinct, sequenced transitions along the development trajectory beginning and ending with the social-public domain (quadrant 1) of psychological space; that is, in sequence, *appropriation, transformation, publication* and *conventionalization.* The following diagrams succinctly summarize these ideas in terms of the four quadrant areas demarcating discursive psychological space discussed in the previous chapter:

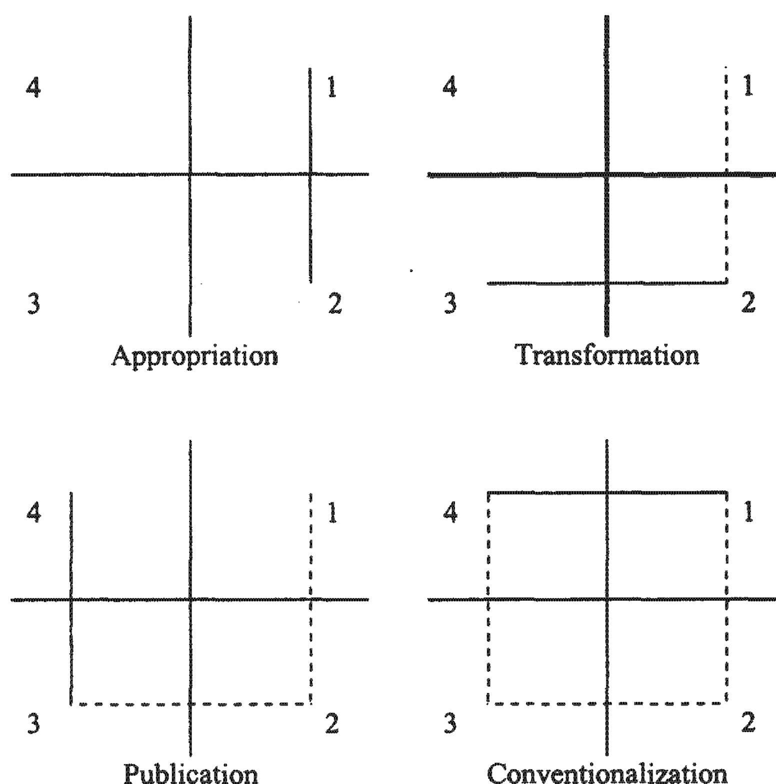


**Figure 2**

We will review each of these genetic domains and their developmental interfaces in some detail in this chapter so to contextualize the position of psychological development which must appear at the very epicenter of a possible clinical model; that is, clinical implications necessarily assume notions of evolution and change.

The chapter is therefore structured according to the natural developmental cycle of individual ontogenesis, beginning with the psychological symbiosis of infancy and concluding with the creative

contributions made by individuals to developing the social order; that is, the development of the original developmental matrix. During the process of this discussion, we will consider important theoretical influences which have both informed and opposed Harré's developmental assertions, and demonstrate how his philosophical position remains consistent while contributing important new insights into developmental psychology and the psychology of change more broadly.

## APPROPRIATION: THE DISCURSIVE MATRIX

This transition encompasses process which involves the appropriation of linguistic forms and social practice present in the circumambient social order by the individual through internalization processes; *psychological symbiosis* is essentially responsible for this appropriation process. This may occur both during infancy and early childhood or at any time during an individual's life time since symbiotic relationships involve the supplementation of the psychology of one animate being by another in order to facilitate the transition process. Therefore any person learning a new task, a new language for instance, or finding themselves immersed in a new moral order as might an immigrant in a foreign country, could partake in psychological symbiosis with another as a means of learning the necessary social skills. Infant and early childhood psychological symbiosis is, however, a special case since it provides us with *pre-verbal forms* of thought, our basic psychology. How are we to understand this special developmental stage and its relation to later development which is essentially grounded in socio-linguistics? In order to understand this process better, it is important to identify how Harré has been influenced by the important contributions made by Vygotsky (1962). Similarly, the revolutionary nature of Harré's ideas can only be appreciated by juxtaposing a critical consideration of the epistemological heritage of cognitive-behavioral developmental psychologists such as Piaget (1970), Kohlberg (1976) and the psychoanalyst, Freud (1949), all Realist models, who, conversely, posit *bio-individualist* interpretations of psychological development. We therefore turn now to clarify Harré's notion of appropriation during infancy, early and later childhood as well as during adulthood. Pre-adult appropriation can be roughly divided into three sequential stages: the *Autonomous Non-Precursor World*, the *Autonomous Precursor World* and the *Transition World.* We will consider each of these before reviewing appropriation during the *Adult World.*

### Autonomous Non-Precursor World

At the ontogenetic level this first childhood world occurs from infancy through to four or five years old, and is characterized by social relations which Harré strongly emphasizes are in no way transferable or precursors to the later social worlds of adulthood or childhood. Harré (1974) refers the reader to Bowlby (1969) for his analysis of attachment and loss patterns in childhood for an understanding of this autonomous non-precursor world:

*"It seems to me that Bowlby ... has made out an extraordinarily strong case for his `attachment ' analysis of the child-mother social world, that develops its form during the first year of life, flourishes as an autonomous culture until the end of the third year, and declines in importance thereafter."* (p. 246)

Harré does not write much more about the nature of this world except to reinforce the notion of its autonomy and non-transferability to the later childhood and adult worlds. He does however point out in Harré (1983) that this dyad communicates primarily through emotion, that is, feeling responses imbued with social meaning, rather than through the conventions and rituals that typify later social relations. This appears largely to be a function of the asymmetry in the discursive rights and capacities of the infant in relation to its mother, who must provide all the necessary supports and interpretations of the world for the infant (Shotter & Gregory, 1976). In order to flesh out this scant picture of this first symbolic world and understand its links and implications for the later worlds of childhood and adulthood more fully, we will briefly consider Vygotsky's theoretical treatment of biological ontogenesis in relation to Harré's ideas. Thereafter we will review early ethogenic studies of the peekaboo game typically played by mothers and their very young children (Bruner & Sherwood, 1976) in relation to these theoretical assertions.

It is important to note that although Harré initially posited a developmental social psychology based on Wittgenstein's (1953) and Mead's (1934) contributions, he only later became aware of the crucial work of the Soviet developmental psychologist, Vygotsky, who formalized and clarified the generative mechanisms involved in the appropriation of the social environment by the very young child. In retrospect, Harré (1993) acknowledges the Vygotskian schema as representative of his principal ideas concerning developmental symbiosis in childhood:

*"The general theory of how skills for accomplishing joint actions are acquired had already been formulated by Vygotsky ..., though I for one knew nothing of this. If all action is actually or potentially joint action, because social acts exist only in the interlocking displays of an actor's intention and of an interactor's uptake, then we can imagine a preliminary stage in which one member does all the act-creating work for the pair. This was Vygotsky's "zone of proximal development". Gradually the junior member takes a greater and greater share in the joint production" (p. 26).*

Vygotsky identified two primary genetic domains, one ontogenetic and the other phylogenetic. The first of these pertains to the development of individual minds while the latter concerns the evolution of socio-cultural structures, tools and signs, which comprise the essential contents of mind. Tools refer to implements designed for reshaping the external, material world, while signs pertain to 'tools'

which shape the mind, internally, and provide the basic structural elements of psyche, words. It is the symbolic sign system implicit within language that informs the genetic link between these two opposing domains. The individual internalization of signs as mental tools is mediated through 'talk' within social relations; that is, collective activity. Consequently, ontogenesis is sharply divided into two phases of development, a *biological* and a *socio-cultural,* which is exclusively a function of bio-developmental constraints. That is, between the ages of three and five years old, neurological development in children reaches a critical point where they are able to use the tools and signs of the socio-cultural worlds surrounding them. These are mediated through symbolic language in the form of interpersonal 'talk' or discourse from a more skilled to a junior interlocutor; that is from the *zone of proximal development* to the *zone of actual development* within the dynamics of the symbiotic dyad. Although Vygotsky concentrated on the so-called higher mental processes of abstract reasoning, his formulation of the generative mechanisms involved in the appropriation of the social world during ontogenesis fully supports Harré's project. These generative mechanisms and biogenetic phenomenon are understood to be culturally ubiquitous by both Vygotsky and Harré; this is reinforced by substantial cross-cultural Empirical evidence (Harré, 1974).

Vygotsky maintained that the biological line is characterized by simple stimulus-response thinking, typical of the ideation involved in animal cognitive activity, for instance, and, furthermore, that Piaget's notion of sensori-motor intelligence is especially pertinent to children's thinking during the biological developmental phase. However, unlike Piaget, Vygotsky strongly supported the idea that this form of thinking does not evolve *naturally* through progressive qualitative stages, from concrete to ever more abstract cognitive operations; he believed that it is entirely subsumed by the phylogenetic line of development with the advent of language skills. In this sense the biological line of development is *autonomous* and in no way informs the social structures and episodes of the later childhood and adult worlds. Harré (1983) points out, furthermore, that Piaget's qualitative distinction between concrete and abstract thinking might be better conceived as possible modes of thinking available to any individual at any age given different activities. Moreover, he maintains that Piaget's hierarchical organization of these different modes of thinking can be traced to the ethnocentric values implicit in Piaget's educational heritage. However, it does seem feasible that sensori-motor development, while appropriate for manual activities at other ages as well, might well be the *dominant* cognitive mode of the infant and pre-linguistic child. This view seems especially viable if we consider early ethogenic research into the peekaboo game. Consider the following possible evolution of peekaboo penned by the authors (Bruner & Sherwood, 1976)):

> *"When peekaboo first appears, our mothers often report, it is an extension or variation of a looming game in which the mother approaches the child from a distance of a meter or so, looms towards him almost to face-to-face contact, accompanying the close approach with a*

*'boo' or rising intonation. ... looming produces considerable excitement and ... when looming is directly towards the face, a real or incipient avoidance response. ... (A)t the start, peekaboo involves an arousal of responses which is either innate or fairly close to innate. ...disappearance and reappearance are 'manipulations' of object permanence, which itself is either innate or maturing through very early experience along the lines indicated by Piaget (1954)."* (p.60)

The researchers suggest that once this response system occurs, there rapidly evolves a set of reciprocal anticipations in mother and child that begins to modify it and to conventionalize it. Importantly, the behaviour of the infant calls forth a certain sub-range of the possible speech-acts available to the mother, ensuring the suitability of her supplementations. This sets out the agenda for the possible psychology created by supplementation. In so far as these early forms of infant behaviour are biological, seeking a food source, for example, they are universal and so set boundaries to a supplementation process (Harré, 1983). The early version of peekaboo, for example, involves a limited range of hiding instruments, masking acts, vocalizations and time variations and a delimited set of small capers. Thereafter systematic introduction of variation occurs within the constraints of set basic rules: *Initial Contact, Disappearance, Reappearance, Reestablished Contact.* Within this rule context, there can be variations in the degree and kind of vocalization for initial contact, in kind of mask, in who controls the mask, in whose face is masked, in who uncovers, in the form of vocalization upon uncovering, in the relation between uncovering and vocalization, and in the timing of constituent elements. Through the reciprocal interaction between patterned variation within constraining rule sets, the child is able to master competency through variations on regularity. This is similar to any process involved in any form of concept attainment. Within their interpersonal system the child's arousal levels and feeling states are quintessential elements in the game; that is, not only is it designed to create pleasurable emotional experience for the child, but mothers, for instance, tended to alleviate their infant's fear by hiding their own instead of the infant's face when starting to play peekaboo for fear of upsetting the child.

The salient, defining features of the autonomous mother-child social world, that is, a loss and attachment orientation, the dominance of sensori-motor cognitive operations structured around a socially evolving rule system with emotion at the center, clearly emerge in the peekaboo study. It seems therefore that this scenario captures the essential elements of the autonomous non-precursor world of early childhood. The non-transferability of this world to later worlds is perhaps the most important element to emphasize in a discursive conception especially since this is in absolute opposition to the 'formative determinism' schools of thought found in the psychoanalytic view, for example, which tend to view all later developments as repetitions of this earliest world - this has

important implications for effective therapeutic practice and is discussed and demonstrated in Chapter 9..

**Autonomous Precursor and Transition Worlds**

The Discursive Psychology view is quite revolutionary in its conception of these childhood and adolescent worlds which are understood to inform the blueprints for the later moral orders constructed by adults and not vice versa. Most distinctive to these worlds is the emergence of language games in the structuration of interpersonal roles and positionings. Harré (1983) writes the following with regards to the autonomous precursor world:

> *"This (world) is characterized by the use of verbal and other symbolic means to create and maintain social relations in wholly conventional style".* (p.247)

There are however also important differences between this world and the adult worlds which emerge later. Most importantly, psychological symbiosis is distinctive from those that precede and follow on; that is, the structural displays of collective psychological attributes, such as rationality, are defined by all the locally construed members rather than as a function of superordinate social convention and ritual alone. Therefore challenges to hegemony can take place; moral order rule-systems can be re-negotiated and re-formalized according to common consent or through the initiatives of alternative arbiters of correct action. For instance, in their study of nicknames, Morgan, O'Neill & Harré (1979) demonstrate how personality presentations are controlled institutionally by highly idiosyncratic nicknames. These are by definition germane only to the worlds they belong. In this sense, these childhood worlds are autonomous since the *content* of these worlds is quite distinctive from that of the adult world to which they are also precursors. The latter sense pertains wholly to their *formal* nature as rule-governed collective activities mediated through verbal-symbolic means. On the other hand, the game of marbles or tag may consist of almost unvarying rules and conventions as it is taught from one generation of children to the next by the children themselves, without interference from the adult worlds surrounding them. Indeed socio-historical research conducted by Opie & Opie (1959) identified consistencies in children's games over a period of four centuries! Apart from the very stable nature of these worlds and the former distinction pertaining to psychological symbiosis, all other formal characteristics of these worlds resemble absolutely the later worlds of adulthood;
Harré (1983) writes:

> *"Like adult social worlds they are maintained by certain linguistic practices through which social relations between people (such as friendship), between people and things (such as property) and between groups of people ( such as team games and social hierarchies) are regulated, and by which norms and standards for personality, character and physical appearance are promulgated". (p. 246)*

Chapter 7 discusses a clinical case study investigating the discursive disjunction experienced by a nine year old boy between the adult and autonomous precursor world.

The transition world found between the autonomous precursor and adult worlds is, similarly, principally differentiated on the basis of altered content; the formal properties above remain constant. The transition world is characterized by content which contains elements of both the autonomous childhood worlds as well as adult rituals. During this stage the young person begins to practise the social forms which they will later be called to master as adults. Adolescence is typically linked to this world. The adult social worlds are therefore simply transformations by substitution of content of the more stable and historically resistant societies children continuously recruit to and maintain for themselves.

**Adult World**

Within adult worlds, that is, where rules, conventions and story-lines have been created by adults for co-existing actors, appropriation of moral behaviour between interlocutors is mediated as much through moral *competency* as by socially endorsed *rights* for specific actors; that is, through social institutions and practices. Adult social worlds define the actors' participant roles and assign duties, rights and obligations to members for appropriate moral displays within local moral order. This applies to any actor present within the circumambient setting: child or adult, man or woman, ill or healthy persons, and so on. Harré's meta-theoretical emphasis on the universality of moral order rule-systems suggests that the question of moral development should comprise a central position in this analysis. How, therefore, might we understand the growth of moral responsibility (personal agency) in context of psychological symbiosis within adult worlds? We therefore must review the defenses against a Realist bio-individualist argument in an effort to continue the clarification of the developmental trajectory of individual appropriation within moral-social order as conceptualized by Harré Discursive Psychology.

Kohlberg's hierarchy of moral reasoning, a capacity based typology of moral development modeled on Piagetian notions, comprises an example of a moral order belief system which positions children within adult social worlds in a typically patronizing position. Indeed, Harré (1983) maintains that rather than presenting any definition of the actual processes involved in the development of moral reasoning from childhood to adulthood, Kohlberg's typology simply serves to endorse ethnocentric North American beliefs about moral life. Typologies of this sort place immense limitations on children's access to moral responsibility and power thereby limiting the nature and range of the possible positionings that young people might orchestrate within the adult social world. It is however

interesting to note that children may actively exploit the disjunction between their actual capabilities and ceded rights by positioning themselves in both adult and child positions to their advantage. For example, Davies (1982) shows how primary school children demonstrate that they can use adult moral reasoning by applying a moral principle universally, something Kohlberg restricts to adolescence. They simultaneously however remind the teacher that engaging in this form of moral debate is inappropriate for an adult since they are only little kids; thus turning the *moral* debate to their advantage; individual agency during childhood might involve instances of the exploitation of moral affordance inequalities for children and adults within family systems.

So too inequalities exist for men and women concerning restrictions on acts of personal agency as a function of ceded moral rights and assumed capacities in different areas of concern. Men, for example, might have high capacity for decisions about appropriate emotional displays with their spouses but a limited right to such displays given beliefs in male stoicism. Conversely, a woman might have considerable capacity to determine the financial priorities in the marriage but might lack the appropriate right to articulate this given her dependent subject position (Hollway, 1984). The research will attempt to demonstrate these Discursive Psychology ideas through an explication of the dynamics of conflict within heterosexual conflict (Chapter 8).

Similarly, the personal agency of individual people positioned as mentally unsound within adult psychiatric discourses (Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995) might be understood as being similarly constrained in terms of the rights/capacities disjunction. Indeed the case study research will attempt to demonstrate how implications of this disjunction might serve to reinforce pathological self identities and subject positions within psychiatric discourse and create the necessity for forging 'pathological' moral careers (Chapter 9).

From these forgoing arguments it is clear that moral development within adult social worlds is as much contingent on available access to the right to act as a responsible agent as the capacity to do so. These constraints are embedded within the discursive fabric of the public-social domain (quadrant one) and are *appropriated* by individuals through the process of psychological symbiosis through their developmental path from quadrant one to two, the collective-private domain. We consider now the *transformation* of social discourse by the individual in their journey from quadrant two to three, the private-individual domain.

## TRANSFORMATION: THE DEVELOPMENT OF SOCIAL AND PERSONAL IDENTITY

Identity is manifested in quadrants one and three of Harré's basic psychological space; that is, respectively, identity as a social being and identity as a personal being. Each mode can inform a person's striving for uniqueness, for the transformation of the social order in some form. We will review possible transformation within each of these modes in some detail in this chapter, however, before turning to a full discussion of their occurrence, we must consider briefly the aspects of psyche that indeed make the event of individual identity possible. That is, typically individuals in different cultures subscribe to a self theory in order to inform concepts of the creation of self- and person-hood. As psychological symbiosis dissolves and the junior party begins to take over the work of the dominant member of the dyad, including the people making work in Western society, this self theory facilitates the occurrence of two critical conditions for personal development: reflective cognition or *self-knowledge* and reflective action or *self-mastery*. Each makes possible identity projects through the operation of these two regulatory functions; individuals work towards the achievement of uniqueness within both social and personal being.

### Self-knowledge

Harré (1983) points out that self-knowledge is possible due to at least two semiotic resources:

1) *"There must be an apparatus of self-referential devices available;"*

2) *"(T)here must be a conceptual system providing the wherewithal for identifications, predictions, and so on, itself dependent on the concepts available in the culture and the extent of individual appropriations thereof"*. (p. 259)

The capacity for *self*-knowledge, although seemingly semantically paradoxical, must itself always be understood in terms of *social* relations. For example, Lyman (1970) has shown that the Japanese use the reaction of others, rather than the results of their own self-scrutiny as a technique for self-assessment: a 'triangular diary' is a document created by first writing up a personal problem, as if it were the dilemma of a 'friend', and passing it on to another person for comment who returns with advice for the 'friend'. Self-assessment is therefore a public-collective activity, rather than a private-individual activity. In this regard, Harré comments:

> *"There are obvious connections with psychotherapy and the role of the therapist as 'external conscience'"*. (p. 261)

We will elaborate on the crucial implications of this comment in the following chapter when dealing with psychotherapeutic applications of Harré's meta-theory. What needs to be emphasized here, however, is that these minimum affordances for self-knowledge must necessarily be understood in

light of self-knowledge as *moral* assessment rather than simply as a function of personal history and active individual positioning within discursive pronoun systems. Any self- and personal-identity theory learned by individuals in different cultures which organizes their experience around a central unity could, therefore, be analyzed into the following formal aspects:

1) How am I now? Self-awareness: consciousness as a form of knowledge of one's own states.

2) How it has been with me in the past? Memory: this facilitates the possibility of autobiography.

3) How could it be with me in the future? Personal dispositions: predication on the basis of assumed moral character.

All three aspects of the central unity rely on interaction with the social order; self-scrutiny per se is insufficient. For example, memory is authenticated in social practice as valid or influenced by the workings of hearsay, while one's dispositions are realized in one's interactions with others. Yet the obverse is also valid; self-knowledge is not possible without self-scrutiny. Rather, self-knowledge is coming to see oneself in relation to a *moral order*, where a person finds out where his values lie, decides what he truly wants, and where he stands in relation to those wants. In short, self-knowledge arises through involvement in our actions as those are engaged with others. In a final cautionary word on the subject of 'self-concept', Harré (1983) writes:

> *"...without attention to the way what we think is embedded in local moral orders, the most fundamental psychological issues will be glossed over ...Our beliefs about ourselves, unless set against a thorough investigation of the normative system within which they are to be realized, miss the core of personal being."* (p. 261)

**Self-mastery**

The traditional view of self-mastery opposes ideal moral action informed by a moral order with impulses and compulsions which counter principled conduct. Harré (1983), however, considers both to be instances of a broader, overarching sociogenic principle since the issue turns on whether someone can or cannot succeed in acting other than by realizing an impulse which must refer to a rule or maxim. Both impulsive action as well as self restraining efforts, therefore, comprise cognitive activity on the part of the agent and, consequently, it seems valid to assume that the impulse or compulsion becomes part of the cognitive structure to which the self-organizing activities of a person are directed and both impulse and rule must co-exist within the overall cognitive system. That is,

> *"For the agentive process to occur, that is, for a person to work their way around a cluster of guiding principles, an obsession has to appear as a guiding principle. ... But for the*

*incorporation to be possible there must be linguistic or other semiotic resources available by which the compulsion or impulse can take propositional form". (p. 263)*

Providing oneself with reasons suggests a private discourse (Kenny, 1975) in which such speech acts as self-command can be performed. Harré (1983) outlines two conditions whereby such a discourse is made possible:

*"1) The actor must be in possession of a theory amongst the concepts of which are devices adequate to set up a dialogue in which he or she, the actor, appears in more than one part;*
*2) There must be a public discourse to serve as a model for the private discourse realizing local conventions of debate, command, reprimand etc". (p. 264).*

Harré points out two interesting illustrations of these ideas, both embedded firmly in general psychological theory. The first pertains to the existential notion (Sartre, 1958) that moral worth might be informed by the extent to which an actor is free of any constraining moral axiom. Harré (1983) maintains that acts of pure agency are themselves expressive displays in accordance with a local principle; that is,

*"...the principle that the greater the degree of reflexive self-control that can be exerted, and the ultimate degree will be that in which action is unconditioned by any rule whatever, the greater the moral worth of the actor". (p.262)*

The second concerns Empirical research and theory into 'locus of control', a fond feature of many undergraduate psychology textbooks as well as an important guiding principle for traditional psychotherapy; that is, the extent to which an internal as opposed to an external locus of control can be created through the therapeutic process within the individual patient. Harré claims that

*"Research on 'locus of control' has ignored issues of the relation of implicit distinctions in locus of control to local moral orders". (p.264)*

He points out, for example, that to casual observation, there are distinctive national and cultural differences in these matters. For instance, in the United States, people tend to adopt 'external' supports for self-control: medication, group support, gurus, marriage guidance, psychiatry, health farms and even road signs. In Europe and Japan, however, personal or 'internal' control takes the upper hand.

Despite the relativity of these Social Constructionist underpinnings, Harré (1983) does ground these arguments in more solid, Realist assumptions. He specifies, for instance, that

> *"The moral assessment of human beings is only by reference to 'strength of character'". (p. 272)*

That is, while local *moralities of will* provide the grammatical forms for the development of individually directed identities, paradoxically, it is only through moralities of the will that personal power is possible; *personal* identity is necessarily carved out from the discourses surrounding individuals as a function of personal decision-making, freely chosen. Without the social capacity and right to articulate moralities of will, however, individuals may be restricted in their range of choices, although theirs is *always* the personal power to act (Harré & Gillett, 1994):

> *"One makes a rule-governed response in certain conditions because that response will usually empower one to exploit some feature of a situation. One may choose to use or not to use that power for any of a number of reasons (and any of those reasons might or might not be the kind of thing that would be endorsed by most of those sharing the social context \ discourse). Someone might, for instance, just be non-conformist, contrary, or perverse. Their behaving thus and so by exhibiting certain meaningful activity is ... (a) reference to their own commitments and states of mind."* (p. 121)

Harré & Gillett (1994) points out that understanding so-called weakness of will or *akrasia* might be understood as yet another morality of will: an individual might locate themselves as a "rebel without a cause", for instance, in a discourse where the social context is seen as constricting or featureless and individuals have to stand out of that context and distinguish themselves in order to enjoy social honor. This individual might appropriate those meanings available in the everyday discourses which surround them, but choose to act in contrary ways in order to fulfill this higher order moral principle. It is important to note that Harré maintains that an analysis informing why a certain individual might choose a conformist as opposed to a non-conformist path to social honor, or any other kind of moral career or chosen discursive location, is not clear since the very nature of his position on the human subject identifies a crucial link between personality and freedom. However, the limits of this freedom can only be articulated within the confines of the moral rights, privileges and duties afforded that individual, on the one hand, and the skills and capacities developed by the individual, on the other, within the limitations of the moralities of will available within local social discourse.

**Social and Personal Identity: the Achievement of Uniqueness within a Moral order**

Social identity refers to attributes an individual shares with others that make up some relevant reference class, while personal identity pertains to those traits identifiable as specific to an individual only. The two aspects of identity are however interrelated since a social order is necessary for uniquely individual elements to emerge, while moral life is only possible given potential variations

from normative socialization practices. We will however focus firstly on identity *projects* which may occur at both the social-collective and individual-private levels; both inform individual efforts at creating a distinctive identity *within* the confines of social moral order. Thereafter we will review Harré's assertions concerning the private *creation* of difference, where radical discursive innovations begin to emerge, which may ultimately transform the initial structures appropriated from the social order. These two aspects mark an important distinction within the developmental trajectory; that is, identity projects pertaining to individual agency within the confines of existing social order, while personal being in its most extreme form explores innovative development of the existing social order through the creative activities of individual agents. The former lies conceptually closer to quadrant two while the latter is essentially associated with activity in quadrant four. Both however inform differing aspects of transformational developmental processes. We consider now the pursuit of social identity projects before turning to personal identity projects.

**Social Identity Projects**

Harré (1983) maintains that through the study of individuals with marginal identities, it becomes feasible to study the processes involved in the assimilation, maintenance and change of social identity. 'Marginal identities' might include people who do not share but aspire to share a certain identity, for example, immigrants, people moving from one social world to another such as the socially mobile or children on the way to being adults etc.. These people are in a position to experience a disparity between their publicly displayed beliefs about themselves and their private aspirations. These disparities suggest the possibility of projects in the realization of which such disparities might be remedied and resolved. Social identity projects such as these necessarily assume two important initial elements for their occurrence:

> 1) *"In order for there to be the possibility of an identity project of this sort, one has to know what the desired social identity might be and, furthermore, one has to be right about them."*
> 2) *"... the next step is to convince others that one has these attributes and that one has them as a right, whatever the right may be. For example, it may be necessary to perform in such a way that others take one's social attributes to have been inherited, and so on."* (p. 274)

Efforts at creating positive social identity projects can be separated into two categories:

1) Such attributes as correct speech, proper manners, impeccable dress, appropriate job, and so on, must be displayed in the right circumstances and with the right degree of authenticity.

2) The construction directly, or by implication, of an appropriate biography or autobiography, for example, changing one's name to 'de' or 'von'.

On the other hand, negative identity projects might involve the preservation of a social identity which may be threatened by social influences which denies its existence. The task at hand would involve convincing others that the existence of an intact social identity despite their constructions to the contrary. A foreign student at school, for example, might explain their position from within an alternative status hierarchy.

**Personal Identity Projects**

Unlike the marginal identities discussed above, personal identity projects involve the dilemma of being both a worthy exemplar of a role position in society and yet simultaneously maintaining a sense of individuality. Personal identity projects depend upon an individual already being established in a particular role position or in some more general social category. This sense of established identity must be both agreed upon by important arbiters of correct action and others in the social environment, and endorsed as a publicly displayable right. Harré (1983) identifies the following types of social positions as instances of established roles:

> *"We would be dealing here with centrally located people such as certified office-holders, arbiters of social propriety such as the powerful women who determine what is and what is not upwardly mobile speech..., well-defined role-holders such as bank managers, policemen, members of the picket line, males who believe they are men, and so on."* (p. 276)

How then might these individual actors create personal identity in the midst of a tight-knit social order? Harré suggests the following guiding principles:

1) Role performances must be presented with a 'stamp' of one's uniqueness (Hollis, 1977). Physical peculiarities and different names mark one form of difference, while a particular style of conducting role requirements plays the most important role. Presidents or other official people mark their term of office with a specific modus operandi which makes them distinctive. They may be the 'peoples man', the 'revolutionary', the 'skilled bureaucrat', and so on.

2) Interpretative procedures whereby others are able to see the role player as a distinct person must occur in complement to the activities of the actor. The task of the person attempting to transform the distinctive social role with their particular stamp of uniqueness must convince others that they are in possession of these distinctive attributes. Many of these attributes would be invisible such as ancestral or genealogical worth, or private thoughts and feelings.

3) Identity projects (both social and personal) necessarily require social display because they involve the achievement of collective convictions.

Thus far the discussion has centered around the sane agent, actively maneuvering in the social world through personal being. Transformation of the social order is principally in relation to specific

positioning within a social context. We now turn to consider the implications of a deeper level of agential transformation of the social order, which targets the transformation of the common stock of collectively imposed uniformities into an unstable structure of individually modified conventions.

**Identity as Personal Being: the Private Creation of Difference**

Harré, drawing on Saussure (1974), outlines two important conditions which must underpin considerations of *meaning*, the analysis of which informs any exploration of the private transformation of the collective-public models of self. These include:

1) *Value*: this involves the intrasystematic aspect of meaning, where the item in question is located at a node in a network of relations to other items in the same semantic system. For example, sequential organization, adjectives preceding nouns in English, and 'please' and 'thank you' conventions etc.. Substitutive items may also stand for an item such as 'Would you mind...' or 'It would be appreciated if you ...'.

2) *Significance*: this involves the extrasystematic aspect of meaning, where the item refers to denoted objects and social acts achieved. For example, establishing friendly, cordial or intimate social relations.

Following Wittgensteinian thinking, Harré points out that value and significance are integrally interrelated; together they serve as set rules of use . 'Horse' and 'steed' may be mutually substituted, yet the real existence of a horse, the extrasystematic reference, must occur for the creation of meaning. Similarly, the social value of an *action* is intimately linked with the social significance of action as *act*, that is, with the extrasystematic significance of the action in the social world in which it has a place. By placing intentionality into this socio-linguistic orientation, it is possible to formulate a position on individual, private contributions to social meaning systems.

However, Wittgenstein points out that the possibility of a private language casts doubt on the stability of any semantic system which attempts to maintain meaning by some sort of private denotation; there would be no common semantic grounding in the public domain. In this regard Harré (1983) writes:

> *"At the most private-individual meaning could inform a private fantasy and the dreams of the mad, but not for long. Yet we feel, perhaps, that part of what it is to have a place in a* ***social*** *order as a* ***personal*** *being is to be able to contribute to the conversation of the primary structure some disclosure of thoughts and feelings that are uniquely ours..."* (p. 282)

Therefore Harré considers the possibility of two methods for conceptualizing the feasibility of this project; that is, the intentional creation of intelligibility across individual-private space and the social-public domain:

1) Personal meaning may be created through intended figurative speech, or incorrectly used words, including non-linguistic signs, as might be used by schizophrenic individuals, for example. Harré (1983) writes:

> *"The ramblings of mad persons are sometimes provided with meaning by another person. This is a special case of psychological symbiosis, and there are a number of ways in which this might be done. R. D. Laing once advocated a kind of interpretive analysis by which the speech of schizophrenic people could be trawled for expressive and oblique references to their family life. The study of the vicarious construction of personal meaning will involve, in each case, the differentiation of intended figurative speech by the speaker from the interpreter's prior commitments to a certain conception of the public-collective structure or process he or she purports to find embedded in the mad person's contributions to the public discourse*". ( p. 283)

Harré's methodological understanding of a process whereby intended figurative speech, individual-private construction, is deliberately mapped onto public discourse must be emphasized here in relation to therapeutic psychology with the so-called 'mad' (Laing, 1964) and epistemological concerns raised in Chapter 1 - these ideas are discussed in more detail directly below.

2) Personal meaning is individual metaphor. Harré (1983) writes the following on this quintessentially important aspect of his meta-theory:

> *"Metaphorical uses are displacements of lexical items into domains of discourse in which they are not customarily used. We must avoid too ready an assumption that literal meaning is a given. By virtue of this displacement a term, in metaphorical use, 'stands across' a number of applications. ... By standing across a variety of applications a metaphor draws them into relation with one another, creating the possibility for similarities and differences, not hitherto noticeable, to emerge. ... Metaphor is like a Kantian schematism, bringing into being, if apt, the new feature which it serves to express, forcing a similarity to emerge. Similarity is a relation, so the forcing of it in the tenor, what the metaphor is about, reciprocally forces it in the vehicle, the term which carries the metaphor. This mutual forcing has been called 'interanimations' by Richards. In the private-individual quadrant metaphorical discourse provides the wherewithal for us to gain epistemic access to ourselves, to the personal realignments and reformations or transformations of the public-collective endowment I called appropriations, and partly brings them into being. What we will find in ourselves will then be a function of the metaphors available in the public-collective domain. And here the study of personal being connects up with that of*

*représéntations sociales.... This is yet another facet of the principle that we strive to become what the best authorities tell us we are."* (p. 283)

As interanimations, metaphors as personal meaning must modify the conventional discursive stock even if only for brief moments in time. Once these are displayed, however, it is the prerequisite of the public-collective domain to accept their novelty as creativity or nonsense.

## PUBLICATION: A REFLEXIVE PROJECT ANALYSIS

Harré does not consider the transition from quadrant three to quadrant four, *publication*, in any great detail and merely outlines possible trends and research possibilities. Through reflexive self-awareness, therefore, we will review this doctoral project in light of the developmental notions of appropriation and transformation with regards to publication, in order to highlight the workings of the personal creation of difference through metaphor and its practical links with the social domain in quadrant three.

Harré (1983) writes the following brief commentary on the pre-conditions for the possible publication of novelty in the public-collective domain:

> *"Creativity differs from madness, on this view, only in the degree to which it can be absorbed into the collective conventions of the primary discourse to become part of the psychological resources taken for granted by ordinary folk.*
>
> *Once one is in possession of a transformed semantic system one could put it in to work, to become a poet, inventor or madmen. But that will not depend wholly upon oneself, but also upon the cultural conditions and social structures of the community in which one publishes ones private discourse. At this point the study of personal being merges into literary criticism, psychotherapy and the sociologically orientated philosophy of science. "* (p. 284)

In light of these forgoing assertions, a developmental Discursive Psychology interpretation of this doctoral thesis might read as follows: the specific concerns of this thesis represent an instance of and attempt to create interanimations between tenor and vehicle; that is, Harré's meta-theory, Discursive Psychology, represents a descriptive metaphor, the vehicle, of human psychological space at a philosophical level, while the intention of applying this to Clinical Psychology, the proposed tenor, is an attempt to force new epistemic meanings to emerge through efforts to identify (force) emergent similarities between tenor and vehicle. This study hopes to clarify new meanings as they emerge during the research process and serves as an effort at the publication of an alternative reading of

difference, reframing abnormality as acts of creativity within the confines of the moral orders surrounding so-called 'mad' individuals as personal agents.

By undertaking this study, a project isomorphic with R. D. Laing's (1964) is attempted whereby the research process endeavors to map the socially endorsed discourse embedded within Harré's theory as it is applied to social psychology to the idiosyncratic discourses of the mad. Indeed the project follows the developmental trajectory outlined in this chapter: the initial *appropriation* of the Discursive Psychology theory, in context of its nesting within the other discourses of therapeutic psychology, the *transformation* of its grammars in relation to the figurative speech interpretations and overall metaphorical interanimations with the concerns of Clinical Psychology, and the *publication* of these reformulations and altered meaning systems of madness within the confines of everyday psychotherapeutic practice.

There is however a final phase which is beyond the control of this project and, like so much in Harré's social world, is indeed unfathomable and empirically unpredictable; that is, the degree to which this project will itself become part of the conventional stock of mainstream psychotherapeutic practice, its *conventionalization.* This of course will be discerned by the arbiters of correct grammars, and the degree to which the available scientific discourses license the assertions made in this research project. We turn now, therefore, to a consideration of the developmental processes found in the evolution of the structures involved in the public-collective conventional stock, in order to complete a full explanation of the developmental trajectory from quadrant one to four and back again.

## CONVENTIONALIZATION: CHANGE IN THE ORIGINAL DEVELOPMENTAL MATRIX

Harré (1980) points out that two primary levels might comprise any serious Empirical study into the processes informing social change in quadrant one. These include macro-level social systems such as those conceptualized by Marx, and the smaller interpersonal systems nested within these hypothesized overarching superstructures. He maintains that it is possible to conceptualize change occurring at both levels along the following lines:

1) Micro-level alterations might leave macro-levels intact and unaffected, for example, changes in the structure of nuclear families might not precipitate reciprocal changes in the class structures of society. Furthermore, these smaller changes must involve local emergent qualities with idiosyncratic features;

2) Higher level change functions as a selection condition for individuals nested at lower order levels, somewhat along Darwinian lines. It is however critical to note that Empirical study into these macro-systems is extremely difficult and indeed Harré, in his inimitable style, maintains that valid

research may be impossible now and in future. Therefore hypotheses can only be tested indirectly through the truth of their consequences; only the local effects of these large systems are available to Empirical inquiry if these purported macro-systems exist at all! Harré (1980) maintains that all these arguments suggest, therefore, is that

> *"The focus of empirical studies of change must then be on the changes in small scale interactions that can be studied by adequate empirical methods".* (p. 290)

Harré emphasizes, therefore, that changes at the micro-level, in the everyday face to face interactions between individuals, are the only forms of change which may have any real consequence. Harré (1993b, 1979) writes for example that unlike the Darwinian model of social evolution which constrains the possibilities for social change due to its imposed metaphors concerning the survival of the most ruthless, self-seeking individuals within a selection condition, it is possible to conceptualize an alternative theoretical metaphor of social change which represents a parity of regard between persons. In this conceptual system, radically alternative practices might exist side by side as ever emergent micro-systems of intentional, self-creating individual human beings:

> *"I have argued that within the constraints imposed by the historically conditioned social psychologies we already exemplify, and the intensely conservative effects of the social apprenticeship served by our children in their autonomous microsocieties, the knowledge acquired through the use of the new approach in social psychology puts us, the folk, in a position to design new forms of association. Historical and anthropological studies can show us the possibilities human beings have already explored.* ***The task of the reconstruction of society can be begun by anyone at any time in any face to face encounter*** (my emphasis). *"*
> (p. 274)

Harré conceptualizes the occurrence of social change within these micro-systems from two positions: *'natural'* and *contrived* social change, the distinction of which is a function of the advent of social psychology, history and anthropology as scientific disciplines and discursive practices. We will consider firstly change as it occurs naturally; by identifying change as it naturally unfolds, we are in a better position to exploit conditions under which a model for contrived change might be developed.

**Natural Social Change**

The following range of possible changes could occur in small scale social interactions in relation to social 'acts' and 'action' sequences as previously defined:

1) A new convention might appear associating a different action with the same act. For example, acts of social deference and respect have remained constant while specific actions such as titles, gestures and so on, have undergone change.

2) The same action might become associated with a different act. For example, industrial strikes may have begun as efforts to secure higher wages but now seem more associated with workers' power and dignity.

3) The act/action structure undergoes change yet the social micro-structure remains constant. For example, the spread of common law marriage is an institution much like the old, but the rituals leading up to its establishment are different.

Isomorphic with these features, change can also occur in *presentational activities* in relation to the following social elements:

1) Within the acceptable, legitimate range of personas and characters available as proper presentations in society. This includes changes in the stylistic and symbolic devices by which they are publicly displayed. The former may, however, remain unchanged while the latter devices become associated with these in novel ways; the converse also holds, as does their simultaneous occurrence;

2) Changes in the accounting resources and conventions that govern the selection of material that can be brought forward for use in accounting occasions. Moscovici (1976), for example, illustrated the growth in the use of Freudian and pseudo Freudian concepts in accounting in French society.

A theory explaining *how* such changes occur also needs to be articulated. Harré (1980) draws on biological evolutionary theories in order to map by analogy ideas pertaining to social evolution in quadrant one. Essentially, he outlines two principal aspects of change, which interactively summarize conceptual possibilities. That is, *selection conditions*, at the level of the social environment, and individual *mutant practices* within these environments. Harré (1980) maintains that mutations might occur in two possible ways:

> "*i. Generation by generation social practices are never perfectly replicated. This may be for a variety of reasons which ought to be more closely studied than they have been so far.*
>
> *ii. Deliberate innovation may be attempted, either through 'official' policy and instruments (for example, attempts to change the way people spoke in the seventeenth century by government decree) or through unofficial but coordinated action (for, example, Women's Lib) or through individual innovation (for, example, fashion). Sometimes these changes 'stick', for instance, the change from riding on the left or aristocratic side to the right or democratic side instituted in the French Revolution. Sometimes they fail, as in the effort to eliminate personal moral careers from academic work in Mao's China, by forbidding such practices as putting one's name to a scientific paper.*" (p. 296)

Given Harré's assertion for a mid-level interface between selection conditions considered as the overall or global environment and the mutant practices that can occur at the scale of individual action and face to face rituals, a necessary higher order law explaining a general tendency within this micro-level needs to be formulated. Based on Goffman's (1969) theories concerning the tendency for the expressive order to become increasingly dominant over the practical order in both the public and private domains in fairly closed institutions, Harré (1980) has formulated the following corollary to this general developmental principle:

> *"The official theory of an institution subject to transformation from the practical to the expressive mode is represented in a rhetoric.*
>
> *Thus, although it is abundantly clear that many mental hospitals are places for the confinement of tiresome or awkward people, there is a 'cure' rhetoric dominant in the speech of the staff. The inmates are not referred to as 'detainees' or 'prisoners' but as 'patients'. The staff are not called 'warders' but 'nurses', and so on. Even the disciplinary practices are called 'treatments'.* (p. 300)

Natural change can therefore occur as a function of a wide range of contingent variables. We need now to consider how these variables might be harnessed through the formal discursive projects undertaken in social psychology, anthropology, history and ethology, and projects such as this one which is directed towards applied clinical concerns.

**Contrived Social Change**

In order to achieve these goals, we must consider firstly the implications of change as these have emerged through ethogenic research projects and discursive enterprises, as well as the possible limits, challenges and ethical responsibilities involved within contrived social change. Although the first of these concerns remains to be fully explored in the later chapter pertaining to discursive research, and action research especially, it seems necessary here, however, to point out that in essence any Discursive Psychology project attempts to make *implicit*, non-conscious rule-systems apparent or *explicit*. Once achieved, this information might be used to improve the social conditions within the predominant available discursive metaphors informing correct action. For example, Harré (1980) in attempting to describe how the deliberate exploitation of the generative character of the social world as conceptualized in Discursive Psychology in order to produce different kinds of act/action performances by introducing different kinds of rules, proposes the following hypothetical situation: the social sex marking symbols used in banks, 'Mrs' and 'Miss', might involve a radical difference in treatment of people, for example, whether they can get bank loans or mortgages, etc.. This implicit social loading might be made explicit as a formal discursive regularity which had previously been

unconscious but very active for social discourse with important implications for individuals operating under these discursive constraints. One might therefore amend this situation by deliberately and explicitly introducing the rule that all females are referred to by 'Ms.'. Thus a mutant social practice such as granting mortgages to unmarried woman might be thereby facilitated.

Another important aspect of the Discursive Psychology contribution to social change is both its emphasis on discursive processes concerning accounting systems, such as those discussed earlier in connection with Freudian theory and everyday speech, and the forms of discourse ethogenic research endeavours make possible once explicitly formulated rule-systems are published. For example, studies into football hooliganism conducted by Marsh, Rosser & Harré (1978) stimulated a spread in explicitly formulated terms of the folk ethology that is used to legitimize violent activity amongst football supporters. On the basis of these kinds of findings, Harré (1980) writes the following important ideas about contrived social change which have powerful motivational implications for the undertaking of this doctoral project:

> *"This kind of thing suggests that we ought to make a research effort to find out whether accounting resources are changed by 'representationes sociales', and if they are whether the availability of resources for accounting affects in any way the kind of behaviour that is routinely produced. Then we should give serious consideration to the possibility of the contrivance of social change using the knowledge we would have then acquired, supplementing the little we know, by deliberate supplementations to and sanctionings from accounting resources."* (p. 306)

This optimistic picture however is balanced by the limitations to social change, on the one hand, and on the other, the cautionary ethical concerns of the potential deleterious effects of contrived social change where unforeseen problems might emerge given inadequate monitoring and vigilance.

Limitations apply to two primary microsocial orders:

a) The genetically programmed, the ethological/biological basis of life and interaction, such as sex role markers and courtship rituals. Four categories obtain if a relation between predisposing genetically determined social practices and those that are culturally determined are plotted. Each successive combination category informs progressively lower resistance to extinction as a social practice:

1) Genetically determined acts and actions, for example, male bonding by 'ritual aggression;

2) Genetically determined acts with culturally determined actions, for example, triumphing by victory rolling a plane;

3) Culturally determined acts and genetically determined actions, for example, betting by shaking hands;

4) Culturally determined acts and actions, for example, contracting by signing one's name;

b) The autonomous precursor world of childhood, involving children's private games, ritual markings of friendship, the control of property by verbal formulae, nicknaming, savage reprisals for violations of social norms and so on. Given that Opie & Opie have identified consistencies traceable for four centuries, Harré maintains that as social scientists, psychologists have no idea how these worlds might come under the influence of contrived social change.

Further limitations occur due to the possibility of lethal mutations which might precipitate the breakup of whole communities. For example, Harré (1980) mentions a situation where the established elders in a society lost their power to managers in the associated silver works, and no longer had recourse to the previous mating arrangements, which led to a breakdown of the entire social infrastructure and moved finally towards a nuclear family constellation. These occurrences warn social sciences of the necessity for careful testing in order to establish a social developmental path from one psychology set to another. Harré cites the difficulty in establishing parliamentary forms of government in Africa as a further example of the problems involved in social transition, where institutions have been transplanted into cultures whose socio-psychological basis is very different from those in which the institutions developed. Harré suggests finally that an adequate pretesting ground for new forms of social practices might be the theatre. He especially enjoins the use of experimental theatre where the audience participates in the process of deconstructing and reconstructing a fragment of social life with coordinator players, where novelty can be safely reviewed, experienced and tested. Similarly, the psychotherapist's consulting room might also afford these opportunities and safeguards.

## CONCLUSION

Psychological development in Discursive Psychology involves a complex interweaving of transitional nodes across the four quadrants of psychological space. The developmental process is one that is bounded and yet is in constant movement. Although no telos is identified in this philosophical scheme, bio-genetic elements and the autonomous worlds of childhood are understood to constrain social and individual evolution in distinctive ways as do the prevailing metaphors of change and development held within any given society at any one historical point.

Harré therefore proposes a developmental psychology which is consistent with his overarching meta-theoretical scheme: explanations of socio-psychological change are balanced against the more resilient elements of Scientific Realism, on the one hand, while simultaneously counterpoised with powerful Social Constructionist ingredients; that is, social restraint and determinism in concert with personal responsibility, creativity, freedom and agency. We consider now the exposition of Harré's theoretical and meta-theoretical thought undertaken in these early chapters in light of specific Discursive Psychology research methodology.

Chapter 4

## Discursive Psychology Research Methodology

Drawing from the diverse fields of social anthropology, ethnography, sociology, ethology and traditional psychology, Harré and a broad range of colleagues construct a research methodology for exploring the human social world based upon the firm epistemological substrate of his meta-theory for psychology. Two distinctive periods are clearly present in Harré's methodological formulations: the first involves *ethogenic* research methodology which focuses on his earlier structural model for valid research into social psychology; the second pertains to his work published during the 1990s which emphasizes the 'discursive turn' in psychology more generally, where a wide range of methods and techniques are incorporated from many different sources and disciplines. Both ethogenic and discursive methodology include distinct and specified research techniques and methods which can be usefully applied to psychotherapeutic work. During this chapter ethogenic as well as discursive research methodology will be outlined in detail. Historically ethogenic methodology predates the emergent discursive approaches and will therefore be discussed first; that is, in terms of both its central heuristic principles and in relation to specific methods; the full depth and range of Harré's contribution as it is practically applied to the Empirical study of psychological phenomena can thereby be articulated.

### ETHOGENIC RESEARCH METHODOLOGY

Harré et al. (1985) offer the following comments about the usefulness of the ethogenic method:

> *"The ethogenic approach is offered as one example of how the problem of method can be faced effectively. By employing researchers of different cultural and professional backgrounds, we minimize the effect of implicit cultural presuppositions. Great care is taken in how one obtains accounts, in evaluating talk, and in the observation of behaviour. The results are then negotiated between researchers and subjects. Generalization is sceptical and cautious, with an eye to the historical and cultural aspects that differ between one society and another. The hypotheses about rule-sets and interpretative conventions can even be tested in the performances of experimental theatre. In this way, the method loses its arbitrary features, and at the same time the requirements of methodological flexibility, which are essential in the study of human behaviour, are safeguarded."* (pp. 124-5)

The ethogenic method presents itself as an essentially non-numerical research procedure. Harré maintains that this method replaces the often fictional clarity which experimental and empirical

studies in psychological research pursue through the implementation of numerical research procedure. Ethogenic method is concerned above all with explicating the structural properties of mind and action. Traditional methods of research can therefore offer little to those interested in the mathematical representation of structure. The value of statistical methods remains that of showing how some feature is distributed in a population while their utility in the search for *explanations* is marginal. The ethogenic method was therefore developed partly to improve the scientific status of psychology as well as to revive the connection between other disciplines originally linked with psychology, namely philosophy and sociology (Harré et al., 1985), which might aim at a more complete and realistic research into the nature of mankind. We witness therefore a decided eclecticism within ethogenic methodology, and indeed, in the later publications of the 1990s, for example, Harré & Stearns (1995), there is even the reintegration of statistical methods into the discursive 'toolkit'. Although the methods and techniques per se can be drawn from traditions as diverse as the Empirical (including experimental) sciences, as well as historical, philosophical, sociological, anthropological and ethnographical fields, there is a core methodological substratum upon which all discursive research should be based. We will review these core principles before considering the methodological permutations to these in Harré's later publications.

**Basic Assumptions**

While the experimental method is suited to the investigation of automatic or habitual action, Harré et al. (1985) and Harré & Stearns (1995) point out that other methods are needed to explore the processes involved in deliberate and intentional behaviour. The key to this methodology is the *act/action* distinction since it is only as social acts that social actions are effective. Any research effort should therefore be aimed at the discovery of acts. The performance of different acts however is contingent on various circumstances; the ethogenic researcher therefore draws a parallel between the linguists' notion of competence (resources needed for appropriate action) and performance (the use of those resources in action) in order to fulfill two primary research tasks (Harré et al., 1985):

> *"The one is to discover and faithfully represent the body of knowledge actors use in carrying on their activities; the other is to find how this body of knowledge is put to use* (p.78-79)

These principles in turn inform three distinct entry points for the ethogenic researcher:

1) A close study of the kind of talk often found as part of human action allows for the formation of tentative hypotheses about social and other forms of knowledge used in human activities. This aspect of ethogenic investigations therefore provides the researcher with an idea of the resources for action; that is, the *content* of specified discourses.

2) Real-time studies of *how* actors utilize their knowledge in action calls for a very different technique, namely, the interruption of action, in order to explicate the *process* of specified discourses.

3) Alternative methodology must again be utilized when uncovering the mechanisms involving *individual* actors' actions which are inevitably colored by his or her beliefs about their life so far. Therefore autobiographical reconstruction of individual lives provides insight into both the content and processes of individual agents actions. These central points will be illustrated in more detail as the chapter progresses.

**The Act/action Distinction**

One of the fundamental principles of ethogenic psychology is a distinction between behaviour, action and acts. Two broad classes of behaviour are distinguishable: behaviour that just happens, and behaviour that somebody intended (action). Yet intended action, such as a specific hand movement, can only be understood in relation to the culture which produces it and may mean one thing in Europe and another in America, for instance. Thus a third level of description must be added - that of act - where the same hand movement, moving four fingers up and down, for example, might mean farewell or 'speak-your-mind' in different social contexts. Moreover, there are many kinds of acts that can be performed by the same action, and there are many kinds of actions that can perform the same act. For example, the bodily movement of smiling might be a greeting, a threat, an apology, etc.. Which act it represents on a particular occasion will depend upon the overall definition of the encounter into which it fits and the kind of episode that is taking place. Any ethogenic description of people's activity must therefore use all three levels: as behaviour, as action and as act, in order to make a psychologically relevant analysis of a stream of activity. This distinction of levels has a very important consequence for method. Part of the methodology developed for ethogenics is a technique by which we can discover the acts that resourceful members of a community take themselves and others to have performed.

**Resources and Actions**

The second distinction upon which the methodology depends is the distinction between 'competence' and 'performance' used in linguistics. Linguistic *competence* comprises the body of knowledge an ideal speaker-hearer would need in order to produce and comprehend the sentences of a language. Linguistic *performance* is the actual speaking of sentences on specific, usually conversational, occasions. Resources for social action is the body of knowledge of legitimate projects, rules and conventions appropriate for persons of one sort or another in specific situations; that is, 'resources' are like 'competence', and 'action' is like 'performance'. However, in many cases the resources necessary for complex social actions belong to the relevant groups, different members knowing,

individually, different aspects of the repertoire. An example of this kind of research project seems useful at this point in order to illustrate these essential ideas.

**Ethogenic Studies of Football Hooliganism**

Marsh et al. (1978) conducted ethogenic research into violence amongst supporters of English football matches. It was observed that during half-time two groups drawn from the supporters of the contending sides assembled behind the grandstand. These groups would confront each other in hostile postures, exchanging insults, particularly by reference to sexual incapacity. It was common for a champion to emerge from each side. The champions would mostly never actually exchange blows, but would instead move backwards and forwards in a threatening manner until one had moved off the ground. All of this was taken very seriously by those involved.

In an effort to understand this strange behaviour, the researchers had to adopt an analytical model about which an analysis could occur. They therefore initially adopted two models in order to extract progressively more refined descriptions of performance:

1) A *dramaturgical model* to open up a preliminary analysis; that is, comparing these and other events at the football grounds to the staging of a play;

2) A *ritual model* which articulates the cultural enactment of social structures in real contexts.

Operationalizing these analytical models for research purposes by an outside observer, someone not typically part of the football hooliganism described, required an *ethnographic* analysis since the analytical models used lie on the margins of the society under study. Therefore the ethogenic researcher stands to football hooligans as anthropologists stand to exotic tribes.

This analysis resulted in a description of a sequence of act/actions which were poorly understood and any explanatory attempts simply involved guesswork. By using the outlined models it is possible to hypothesize that certain acts do indeed exist and have something to do with a ritual, although it is not known what the ritual is for. Fortunately people do not just act, they also talk and comment critically upon their actions. This is the principal contribution of the ethogenic method for the study of human behaviour. Talk as commentary serves to interpret the actions as acts. The type of interpretation and what happens in the interpretation form a very important part of an ethogenic understanding, since the nature and status of actions are *transformed* in the interpretative talk For example, in the ethnographic description, at the level of action, it emerged very clearly that fans very rarely actually hit each other. Yet they described them as 'fights' and spoke of blood, of broken teeth, of the

infliction of serious injuries, all of which was reflected in the discourse of local papers, creating a 'conspiracy of interpretation' (Harré et al., 1985).

Understanding these unexpected findings involves insight into the implications of the essentials of Discursive Psychology and its potent epistemological relevancy for questions aimed at assessing the veracity of social knowledge. How then do we interpret these findings? Harré et al. (1985) write the following comments on this quintessential point:

> *"By being so interpreted, these events are redescribed as socially significant acts. The performance becomes a ritual which marks a step in the course of an honourable career. The outcome is defined as an honour-enhancing 'victory'. In the course of the definition, both winners and losers are created, and as a result the individuals so defined change their status within the social order of football hooligans. The change of status is not the result of the 'fight' but the discourse about the 'fight'.*
>
> *Interpretative talk is often used after an event to reinterpret the actions to fit with the existing status system." (p. 87)*

**Justification Talk**

A second kind of talk of a least equal importance is usually produced when something has gone amiss with the so-called normal flow of events. This talk is employed to correct or justify imperfections in the first kind of action and talk. Within this second kind of talk one can find explicit rules and conventions for acting correctly. In essence these rules and conventions comprise the unconscious knowledge which is the true cognitive basis of the production of action. It is necessary to therefore proceed as if these fundamental units were present in any given ethogenic study and finally achieve a coherence test for the whole of the researcher's understanding of the psychological mechanisms. While this methodology can be extremely time consuming, the use of repertory-grid methods (to be discussed later in this chapter) allows for rapid access of these generative mechanisms. Finally it is necessary for the ethogenic researcher to check out the authenticity of the initial hypotheses derived originally from the use of the pair of analytical models by using the analysis of the second kind of talk, the talk people among themselves use to correct or justify their acts and actions.

These accounts of actions are not introspective descriptions of cognitive processes. A human being might be lying about his or her plans and intentions. They may not even know what cognitive processes are appropriate for understanding the action. This is quite irrelevant for the analytical use of accounts. In the production of accounts, actors are displaying knowledge of *ideal* ways of acting and ideal reasons for doing what the may have chosen to do or not. Since on any one occasion quite

different reasons may be in operation, it is only in the long run and for a whole culture that it can be expected that accounts and ethnographic analyses will meet. The following schema represents these crucial methodological ideas in summary form:

**Summary of the Essentials of Ethogenic Research Procedure**

**STEP ONE**

HYPOTHESES 1:

*Concerns the partition of the flow of social interaction into actions as the bearers of the acts they accomplish.*

Is tested by

TEST 1:

*First kind of talk; that is, interpretative talk about action transforms observed actions into acts.*

**STEP TWO**

HYPOTHESES 2:

*Concerns the supposed beliefs of the actors, the implicit rules to which they subscribe, and so on.*

Is tested by

TEST 2:

*Second kind of talk; that is, talk aimed at correcting or justifying imperfections in the first kind of action and talk.*

**STEP THREE**

FINAL TEST:

*Does the whole structure of accounts and hypotheses lock together into a coherent and intelligible combination?*

*This material is represented as a system of rules representing a system of knowledge and belief.*

**Account and Action Analysis: Two Different Methods for Producing Belief-system Hypotheses**

This general procedure for accessing the ultimate generative mechanisms of human action can be achieved by using the *resources / action* distinction. *What* belief-systems exist for specified actors in specified contexts are explicated using the ***dramaturgical analytical model*** which involves ***account analysis.*** *How* these belief-systems are articulated in real contexts by real people, on the other hand, involve the ***actor/script-rule source model,*** an ***action analysis***. We can compare and perhaps conjoin the hypotheses about the different systems of rules that these two models generate for the researcher. If they can be conjoined, then a test for the whole system can be developed by trying to synthesize a new piece of social reality. This is the classical method of analysis and synthesis. Techniques such as role-play, experimental theatre, and soon, can be used (Mixon, 1972; Ginsberg, 1979; Yardley, 1982). In role-play the system of rules discovered in the analytical phase is used to re-create a fragment of social life. Harré et al. (1985) comment that

*"Our intuition of the authenticity of the resulting performance is the test for the whole method."* (p. 96)

We turn now to discuss each of these models in more detail since they inform the primary methodology to be utilized when practically applying ethogenic research principles.

**Account Analysis: the Dramaturgical Analytical Model**

Three different methods can be utilized separately or together to gather empirical information about specific actors belief system resources in circumscribed situations. These include informal account analysis, repertory grids and autobiography. We discuss each of these methods in detail below.

**a) Informal Account Analysis**

Account analysis might occur through simply interviewing actors and structuring interviews in terms of laddered 'Why?' questions. For example, football hooligans might be asked 'Why?' they were congregating behind the grandstand during half-time. Thereafter any successive response would be met with an additional 'Why?' question. In this manner progressively higher levels of meaning would become accessible as to the motivations for the observed behaviour; that is, the executive structures of belief would become known to the researcher through the subject's accounts. This form of analysis is however somewhat long winded and exhaustive analyses might take a very long time. Peter Marsh, for example, took over two years to collect all the necessary accounts to make sense of the football violence study discussed earlier. For this reason other methods of account analysis have been developed to both speed up the account analysis process and access the ultimate generative mechanisms of action. This is because the methods described so far depend on the spontaneous production of accounts. Many important matters are not likely to be mentioned. Therefore more systematic, contrived versions of accounting have been formulated in an effort to promote these goals. These account analysis procedures include the use of *repertory grids* and *autobiography.*

**b) Repertory grids**

On the basis of the work of Mischel (1964), Harré maintains that repertory grids represent systems of rules or rule-like cognitive entities. As ideal conceptual forms, they control the proper way of thinking about people, situations, or whatever is of interest. They represent a system of rules of proper reasoning about that particular set of objects. It is possible to make multidimensional grids of indefinite complexity. The technique was invented by Kelly (1955), developed by Fransella & Bannister (1977), and further elaborated by Shaw (1980). Specifically, the repertory grid method entails the following procedure:

a) The analyst uses commonsense intuitions to define a situation based on ethnographic type observations;

b) Comparisons of triads are then made about the thinking or action people use in that specific situation. For example, suppose one wanted to study 'being at school' as a type of situation. An important feature of 'being at school' is the teachers. The researcher might therefore group the teachers in threes and ask the participants, the pupils, in the study, 'Is Smith more like Brown than he is like Jones?' A participant may say Smith is older than Jones , but not as old as Brown. That participant has used a concept pair (or, 'construct'): old/young. The investigator did not invent the concepts whose polar opposition creates the pair; the actors drew on them for a particular cognitive purpose. The process can be repeated by taking more teachers for yet another concept pair, and so on. These pairs form a grid, a repertoire of devices used for thinking about and acting in situations of the kind 'being at school'. In the end one has an open but detailed conceptual representation of the cognitive resources available to actors, should they find themselves in that situation. The concept pairs are produced spontaneously by the actors themselves and not imposed by psychologists.

c) Informal account analysis, coupled with the repertory grid method will yield a very detailed representation of the knowledge that an actor must have to perform a certain kind of action and to produce the proper kind of talk. As such it is a resource or 'competence' study of the system of beliefs held at a public-collective level. We consider now another important method which helps access the resources involved in *individual* as opposed to collective knowledge.

**c) Autobiography**

Although individuals are born into belief-systems, language communities, and so on, all of which tend to mould people into representatives of a type, individuals are never exactly alike - each has a unique history. A crucial element in our understanding of each individual is knowing about specific individual's beliefs about their own past; that is, their autobiography. However, two main methodological problems exist, namely, *perspectivity* and *imperfect recall* and these need to be discussed in order to fully understand how ethogenic methodology addresses these issues.

Perspectivity can also be referred to as 'situation-specific-memory'. Different aspects of a person's autobiography are called up according to the 'perspective' from which they are, at the moment, reviewing the past. Their current emotional state might even be involved. Depending on the conditions of their recall or citation, *radically* different evaluations of events are made (Helling, 1976). Over a long term period, a person will produce a multiple picture of his or her past life, the richness of which depends on the extent to which the perspectives possible for that person have actually been taken as standpoints from which to recall and order the past. At no stage can an

investigator be sure of having identified all the perspectives a person might occupy in all conceivable life circumstances.

Imperfect recall, on the other hand, involves distinguishing between genuine memories and imaginary events, with all the intermediate grades between reality and fantasy. De Waele & Harré (1979, 1977) developed the method of 'assisted autobiography' in order to facilitate the optimal working of these potential problems. This procedure involves two phases:

a) Phase One: This is a reconstruction phase in which a person under investigation negotiates a compromised personal history with a carefully selected team. The compromise is worked out between their initial and circumscribed autobiographical claims and the several proposals for filling out the initial fragments by the team.

b) Phase Two: Problem and conflict situations are deliberately constructed to prompt recall under well defined emotional conditions; that is, a typical situation with a specific emotional force is produced. This usually leads to rapid recall of the details of other situations similar in structure and feeling. The results of the two phases are then combined to produce a final document.

Using the assisted autobiography method therefore means that it is possible to find out how much of the collective resources for action are available to this or that individual actor in typical episodes of life.

**Action Analysis: Actor/script-rule Source Model**

When attempting to study the moment-by-moment genesis of action, the ethogenic researcher may experience problems accessing these aspects of action since the actor's attention is directed almost exclusively to goals or ends; any focusing on means drops out of conscious awareness. This difficulty can be solved by exploiting a phenomenon well known in linguistic studies; that is, when the system for producing action is not working perfectly, some of it is represented consciously. In other words, when there is a hesitation, we sometimes become aware of how we are trying to proceed, as well as the goal we are trying to reach. It is possible to represent these processes in the form of a working model of how the systems of knowledge are put to use in real time by real actors (von Cranach, 1982).

**a) Engineering Breakdown**

However, the smooth production of action breaks down only accidentally and occasionally. Research psychologists studying 'action' have, therefore, devised ways of making both practical and social activities break down continuously in order to produce a representation in consciousness of most of the system of control; that is, the hierarchy of means and overall and subordinate ends. Von Cranach

(1982) has shown that naturally occurring breakdowns result in explicating approximately forty percent of the control system while it is ultimately necessary to represent over ninety percent of the hierarchy. *Two methods* have therefore been created to ensure that breakdown occurs almost continuously, and include the following:

i) Method One:

Studying people learning a new skill has yielded good results. For example, Kaminsky (1982) has made a very detailed study of adults learning to ski in which, step by step, a control hierarchy of means/end pairs is built up.

ii) Method Two:

a) *Controlled laboratory* conditions have been useful for precipitating situations involving continuous breakdown. Von Cranach, for example, set husband-and-wife teams to work together on fairly difficult practical projects. In many cases a continuous breakdown in the smooth performance of the task occurred because the husband and wife assessed the task in terms of different sub-goals. This in turn led to the choice of different means for achieving the overall goal of completing the task. The clash of goals led to a continuous debate about how to proceed with the project. The control systems for each step of these activities were therefore represented in words. More specifically, the husband-and-wife teams were required to wrap a baby carriage in paper, which is apparently no easy task. To make sure that the smooth operation of wrapping broke down, he provided two different kinds of material - one beautiful but fragile, the other strong but ugly. One member of the two-person team would opt for one set of materials, his or her partner for the other. This led , in the 'best' cases, to public discussion and even wrangling about a surprisingly large number of subordinate ends and appropriate means. The researchers were able to make a representation of the ways that each team member proposed as the best procedure simply by recording the discussion in which nearly every proposed step was debated. The rival schemes were reproduced onto transparencies so that one can project one over the other. It was found that they coincided at certain points and indicated moments when agreement was reached and the actual process of wrapping the pram could proceed. This example clearly articulates the critical concepts involving breakdown, conflict, debate and representation, however, it is a long and tedious process with little real life relevancy. Fortunately, clinically orientated work modeled closely off these methodological ideas has also been conducted by Brenner (1978) amongst problems facing social workers and their clients.

b) The *clinical studies* conducted by Brenner were concerned with a real social problem involving the difficulties that arise between old people and the social workers who have to interview them. Many interviews develop into situations of conflict since the social worker needs to find out about the lives of the old people and the old people want to comply with conventions of polite conversation but also to conceal as much of their lives as they feel should be hidden from a prying stranger. The breakdown occurs because of the different social projects of husbands and wives.

where, for instance, an old man wishes to comply with the law and to therefore answer the questions of the social worker, while his wife does not wish to answer those questions, but wants to give the social worker a good impression of the family. Brenner studied the process by which social order is maintained but the social worker is outmaneuvered. Breakdown occurs whenever husband, wife or social worker separately defines incompatible goals for the next phase of the interview. Brenner represented the means-end schemes involved by systems of rules. In a typical episode of this sort, about a hundred or so rules are used, falling into four systems, some of which are general, having to do with people's understanding of the law and of common social conventions, others being peculiar to a particular family. Hierarchies of overall goals and steps to achieve them appear which are similar to those unearthed by von Cranach's laboratory studies.

**b) Identifying Acts: Methods of Empirical Study**

An ethogenic view of social psychology involves the formation of hypotheses about the belief-systems that actors need to possess in order to be able to produce the actions they do produce with the meanings these actions actually have, and which the actors intend. Part of the body of social knowledge that must find a place in Discursive Psychology is knowledge of the way episodes are put together; that is, the structure of the exemplary forms of typical episodes. Some of the rules that express that knowledge must govern the order in which acts and their actions are produced. We can form hypotheses about those rules only if we know what structures; that is, what orderly sequences of actions, meaningful as acts, are produced by those taking part in typical episodes. We must therefore consider now the methods that Harré and his colleagues suggest for systematically studying the act-action structure of social episodes. These include *computer analysis of sequences* as well as studies involving *anticipation and planning* and *episodes of conflict*:

- **Computer analysis of sequences**

Any sequence of actions or other events can be analysed using a basic three-step procedure.

1) The stream of activity has to be divided into discrete units;

2) The units have to be classified and each event in the recorded data must be represented by the type or class to which it belongs. Actions are classified by reference to the acts they are used to perform;

3) The orderly succession of types making up the pattern of events has to be summarized as a sequence of acts.

This kind of structural research includes differing levels of investigation, from the simplest to highly complex forms. At the simplest level it can be assumed that the kinds of speech acts recognized by investigators are identical with those intended by the actors, where the significance attributed to them is the same for both actor and investigator. This is particularly true for subjects drawn from the same

background as the researchers. A less convincing approach, however, is to study patterns of social action which occur recursively independently of the social episodes in which they are embedded. Indeed, Kreckel (1981) has shown that some such patterns do exist, but that most patterns are specific to the type of episodes and to the particular group of people engaged in the conversation.

With these assumptions in mind, interesting results can be achieved by having subjects arrange the speech act categories provided by the investigator to form hypothetical but plausible sequences; for example, 'plea'-'rejection'-'apology'-'repeated plea'- 'acceptance', and the like. The participants can also be asked to indicate where changes of topic might occur and where whole conversations could begin and end. The resulting sequences can be fed into the computer for analysis, and may even yield surprising results. For example, Clarke (1983) expected that event-types would decline in frequency in direct proportion to their rank frequency, whereas the observed relationship turned out to involve the square-root of rank frequency. The analysis also showed that the likelihood that a conversation will end starts to increase markedly after a certain time has elapsed, but that topics within conversations seem to have no natural time span and their possibility of ending does not suddenly increase, however long they have been going on.

A more complex analysis might therefore involve the reclassification of types of speech acts into larger family groups on the basis of similarities and differences in their patterns. A kind of 'map' can be drawn up showing the most commonly used sequences set out rather like a street plan, on which the joining and parting of ways represents the ways in which different patterns of events can converge upon similar implications for the future, or arise from a common past history.

- **Anticipation and planning**

Investigating how the history of a dialogue as well as anticipations of the future of the conversation influences what participants decide to say at each moment, requires the following procedure:

1) Pairs of participants can be allowed to converse freely, but one of them has been given a special utterance to be worked into the conversation;

2) A third party observes the speakers and the trial is aborted if he manages to identify the inserted utterance;

3) As the conversation unfolds, the speaker who is to make the insertion works a device to record moment by moment how long he or she thinks it would be before the insertion could be made;

4) Signals from the device can be used to produce a graph comparing the time expected to elapse against the real time;

5) Once the insertion has been made and marked on the chart, it is possible to construct a perfect prediction curve, showing the subjects' expectations as always being equal to the real time left to elapse;

6) The actual prediction curve could then be compared with this ideal to show how the subjects' accuracy of anticipation changed as the event grew nearer.

Although Harré et al. (1985) report that studies using this method indicate that an improvement in prediction occurred as the event approached, it was surprisingly late and small. The authors do however suggest that very different results may be expected for an interrogation, a lovers' quarrel, a schoolroom lesson, and so on, and encourage further investigation. In addition to these ideas, the authors are also concerned with the possibility of pre-existing rule-systems which determine the overall structure of the event. The following procedure is suggested in order to test for the existence of such hypothetical rule-systems:

1) Participants provide accounts of proper and improper sequences of events; for example, "It is improper to couple a bid for attention with a refusal to accept an invitation!"

2) Devise a system of rules which relate performance of an act-action to the necessary conditions which a prior course of events, including prior sequences of act-actions, must fulfill;

3) These rules can be used to invent sequences of types of social events (act-actions) which have outcomes not actually found among the situations referred to in participants' accounts. For example, an episode which terminated in an invitation to meet on another occasion could be subtly transformed so that it terminated in a round of farewells.

4) The plausibility of these hypothetical rule-systems would be the willingness or unwillingness of participants to accept new terminations as socially possible outcomes. For example, an exchange of sarcastic personal remarks is most unlikely to end in an agreement to meet again in most western countries.

Clarke (1983) conducted research of this nature and discovered that two classes of rule appeared necessary for the production of acceptable act-actions sequences:

- Class 1: Events expected immediately after a given type of event, for example, an apology following a reprimand.
- Class 2: Events much earlier on in a sequence determine the occurrence of later events. These may also include the non-appearance of act-actions of a certain type. For example, a conversation may be closed with an invitation to further conversation provided that there has been no previous exchange of sarcasm.

- **Episodes of conflict**

Empirical investigations of participants in conflict involves a different method of representing structure if conflictive interaction is to be studied structurally (von Cranach, 1982; Clarke, 1983). Harré et al (1985) suggest that this might reflect a different kind of rule structure since each participant has in mind an overall outcome which they use to organize the performance of intermediate actions which accomplish secondary ends. The method includes the following procedure:

1) Imagining 'ideal' episode structures from the point of view of the various actors;

2) Record the actual strategies and tactical moves used by people engaged in real conflicts;

3) Compare the results of 1) and 2).

The results of studies already undertaken along these lines seem to show that two rule-systems are at work. The one involves control of the overall strategy of action, the most logically coherent strategy - the *strategic rules* . The other involves *rules of reaction* which arise as a function of each opponent trying to realize their own respective logically coherent strategy. The strategic rules can therefore only be drawn upon when the opportunity arises. At other times the actor is concerned to react to, and perhaps counter or neutralize, the efforts of the interactor. The rules of reaction constitute a second-order system of maxims and they interact in complex ways with the strategic rules. In the first instance the rule-systems simply *reproduce* the structure of the conversation and must therefore be understood as hypothetical rule-systems which must be tested for before deciding whether they exist or not in a specific form for each respective interlocutor. This is because the actual pattern of actions produced by the mutual interactions of the opponents is not a perfect realization of either strategic rule-system, but would not exist in the way it does without the use of both of them. Therefore a successive assembling of speech-acts occurs during conflictive interaction which cannot be predicted from the rule-systems alone. This kind of structural explanation is known as an 'assemblage' since there is no overall template on which the structure of the conversation is built.

We consider now methods which have emerged as a function of the sharpening of the 'linguistic turn' in Harré's later works, in which we witness a wide ranging methodological eclecticism for the study of human discourse.

## DISCURSIVE RESEARCH METHODOLOGY

In three important works published during the mid 1990s, Harré and a number of co-editors have produced a corpus of theoretical work which aims at clarifying both the philosophical position and methodological practicalities of discursively orientated approaches. In *Discursive Psychology in*

*Practice,* Harré & Stearns (1995) make the following comments about the two volumes devoted to the discursive approach which slightly preceded their contribution; that is, *Rethinking Psychology* and *Rethinking Methods in Psychology* (the latter provided practical methodology for implementing the more theoretical emphasis of the former):

> *"In both these books several non-experimental but empirically based approaches to the problems traditionally taken as the subject matter of psychology were explained. Each was developed as a well-tried methodology based on a carefully constructed theory. In one way or another each opened up an aspect of the general conception of human beings as active, symbol-using creatures intentionally engaged in joint projects. Since our plan was to make available a wide variety of 'new' approaches we aimed at a fairly comprehensive spectrum of styles and methods."* (p. 1)

In relation to their own book, Harré & Stearns (1995) describe its specific contribution as follows:

> *"This book illustrates the use of some new methods that are animated by one of the major contemporary theories of action. This is the point of view that highlights discourse as the characteristic feature of human life. Our aim in choosing the illustrative cases of research to be displayed in this volume was to provide the reader with sufficient detail and depth to show what the discursive approach could accomplish."* (p.1)

It therefore seems that the discursive psychologist should search these volumes for examples of discursive research methodology in order to fully understand Harré's contribution. It is important to note that although ethogenic psychology has a distinct methodology, in the broadest sense ethogenic methods can be subsumed under discursive methodology. The distinction is therefore largely 'developmental' in origin and need not be overemphasized. Indeed, the creative discursively orientated researcher might 'mix and match' techniques from both periods and may even incorporate other methods which are not discussed yet place discourse at the epicenter of investigative activity. This even pertains to quantitative statistical approaches. This stance is supported since together with his colleagues, Harré (Smith, Harré & Van Langenhove, 1995, 1995b) distils the following *guiding principles* in an effort to point out the commonalities within the divergent methodologies and their respective theoretical roots so to balance a unitary epistemology with a pluralistic orientation:

> *"1) Research conducted in the 'real world'.*
>
> *2) A recognition of the central role of language and discourse.*
>
> *3) Life and research perceived as processual or as a set of dynamic interactions.*
>
> *4) A concern with persons and individuals rather than actuarial statistics and variables."*
> (p. 3)

We therefore turn now to a brief overview of the different methods outlined in these later works. Each method will be discussed in terms of a specified topic area of Discursive Psychology; that is, *the search for meanings, discourse as topic, research as dynamic interaction*, and *adapting traditional methods* for Discursive Psychology.

**The Search for Meanings**

The approaches outlined in this section are derived from the qualitative tradition in the social sciences which were influenced partly by phenomenology (the human experience of being in the world ) and symbolic interactionism (discursive activity). The emphasis here is on trying to grasp the psychological conceptions of participants. This involves conducting interviews or collecting other forms of verbal material, making transcripts of this material, and finally subjecting these and other documents to close textual analysis. The role of the investigator is considered an essential aspect of these approaches since the investigator plays a crucial role in shaping the research project (Smith et al, 1995). That is,

> *"The respondent's story only becomes available through intensive interpretative engagement on the part of the researcher."* (p. 5)

**a) The Semi-structured Interview**

Smith (1995) maintains that semi-structured interviews and qualitative analysis are especially suitable for empirical inquiry where complexity or process are of interest or where an issue is controversial or personal. The stages involved in this approach are: formulating questions, constructing an interview schedule, conducting the interview, analysis and writing up. In the structured interview the interviewer will aim to use short specific questions, read the questions as per the schedule, maintain a predetermined order and even precoded response categories. In contrast, the semi-structured interview would attempt to establish rapport with the respondent, place less emphasis on the ordering of questions, the interviewer is freer to probe interesting areas that arise, and, finally, the interview can follow the respondent's interests or concerns. The advantages and disadvantages of the semi-structured interview are as follows:

- Advantages:
  i) Facilitates rapport \ empathy;
  ii) Allows greater flexibility of coverage and enables the interview to enter novel areas;
  iii) Tends to produce richer data.
- Disadvantages:
  i) Reduces the control the investigator has over the situation;
  ii) Takes longer to carry out;
  iii) More difficult to analyse.

**b) Grounded Theory**

Charmaz (1995) introduces grounded theory as a systematic way of working with qualitative data. It can be incorporated into the analysis phase of the semi-structured interview or used independently. These methods include a logically consistent set of data collection and analytic procedures aimed to develop theory. These consist of a set of inductive strategies for analysing data; that is, starting with individual cases, incidents or experiences, the researcher develops progressively more abstract conceptual categories in order to synthesize, explain and understand the data and to identify patterned relationships within it. Importantly the theoretical analysis follows what the researcher discovers as relevant in the actual worlds encountered during investigations. Most fundamentally, grounded theory methods explicitly unite the research process with theoretical development. Grounded theory might answer research questions which involve studying individual processes, interpersonal relations and the reciprocal effects between individuals and larger social processes, for example, topics such as motivation, personal experience, emotions, identity, attraction, prejudice and interpersonal co-operation and conflict. The procedure occurs along the following lines (Charmaz, 1983; Glaser, 1978, 1992; Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1993):

1) Simultaneous involvement in data collection and analysis phases of research;

2) Creation of analytic codes and categories developed from data, not from preconceived hypotheses;

3) The development of middle-range theories to explain behaviour and processes;

4) Memo-making, that is, writing analytic notes to explicate and fill out categories, the crucial intermediate step between coding data and writing drafts of papers;

5) Theoretical sampling, that is, sampling for theory construction, not for representativeness of a given population, to check and refine the analyst's emerging conceptual categories;

6) Delay of the literature review.

**c) Life Story Research**

Plummer (1995) considers the aim of life story research to investigate the subjective meanings of lives as they are told in the narratives of participants. There is much to be gained in psychology from the use of life stories since they take seriously the subjective dimensions of lives while also enabling them to be placed in a fuller social context. Furthermore, the narrative nature of human conduct is fully acknowledged. The research process involves five important steps. These include:

1) Selection of a life story: for example, the marginal person, or famous or so-called ordinary people;

2) Collection of data: a non-directive, phenomenologically aware researcher might use the non-directive counseling model as a useful yardstick of method since all the rules of non-directive

counseling come into play here. Central to this view is the uniqueness of the person and the situation, the importance of empathy and the embodiment of 'non-possessive warmth' in the interviewer. The aim is to grasp the interviewees point of view, his relation to life, to realize his vision of the world. The informal interview discussed above will also usually have a key role to play;

3) Organizing records: various methods may be utilized, however, it is vital to organize material effectively since life history research notoriously produces a mass of data;

4) Inspecting the data: firstly, the respondent might lie, cheat, present a false front or try to impress the interviewer in some way - these 'demand characteristics' need to be identified where possible; secondly, the interviewer must account for personal prejudices, expectations, background and general life orientation which might distort validity and reliability criteria; thirdly, the interactional encounter should promote the goals of the research, for example, the setting should be a fine balance of formal and informal characteristics;

5) Writing a life story: this involves a choice of rendering a *total life story*, or a more focused approach, the *topical life story*. A further choice must be made where a position along a 'continuum of contamination' must be selected; that is, the degree to which the original words of the participant are used in relation to paraphrasing, interpretation, thematic analysis, and so on, made by the researcher.

**Discourse as Topic**

Smith et al. (1995) consider methods for studying *discourse* per se. These include *conversation analysis* and *discourse analysis*. Much of this work dovetails with concerns outlined in ethogenic psychology. Each aspect will therefore be dealt with briefly and highlighted in terms of Harré's project:

**a) Conversation Analysis**

This approach explores the intersubjectivity of conversational structures, organizations, devices, and so on. This involves two elements: firstly, identifying those organizations or devices in conversation to which participants orient, which is manifested in their verbal behaviour (resources); secondly, to locate those common sets of procedures and methods which facilitate symmetry between the production of interpersonal discursive activity and its interpretation (performance). In conversation analysis there is an effort to identify ways in which participants themselves orient to, display and make sense of one another's cognitive states. Specific techniques and methods for conducting conversation analysis studies are complex and varied and require careful explication. The ideas posited by Drew & Holt (1995) and others conducting conversation analysis studies in *Rethinking Methods in Psychology* amount to secondary elaborations of ideas already outlined in Harré's earlier

works and therefore need not be discussed in any detail until specific conversation analysis is conducted.

**b) Discourse Analysis**

The practical issues pertaining to discourse analysis (DA) as well as a brief consideration of theoretical principles are engaged with by Potter & Wetherell (1995). Once again their ideas closely parallel Harré's project especially as their central goal is to demonstrate how the interpretative repertoires available to people through cultural discursive practices inform their social activity; any of the methods discussed by the authors could be applicable to Harré's pursuits. These methods typically involve interviewing, transcription, coding and variability. Interviewing in DA might also consider the interviewer's contribution to the conversation and may indeed be a topic of research in its own right since both the subject as well as the researcher's talk involves interpretative repertoires and resources underlying social activity. Transcription in DA can be a very laborious task and the authors point out that transcript comprehensiveness should be balanced with the specific task at hand, although this is no mean feat to achieve in reality. They however do encourage the use of the Jeffersonian system which includes most speech errors and pauses and gross changes of volume and emphasis. Coding is also used in this method to ensure that the sheer bulk of collected materials and data is made more manageable. That is, the material is scanned for any number of themes, for example, those issues that stimulated the study in the first place while others may emerge as a function of the interview process per se. Themes may emerge, disappear and re-appear in an organic unfolding process. All however would be substantiated by considering both the interviewer's position and the 'facts of the text' which should be articulated as fully as possible. Variability places the intra-textual thematic variations in a central position in DA since it is only through contrast that it is possible to create a meaning system which articulates the interpretative repertoires available to subjects, including the interviewer!

**Research as Dynamic Interaction**

Two methods are discussed by Smith et al. (1995) which both make the process of social interaction the very substance of the research itself. These include *role play* (Yardley, 1995) and *co-operative inquiry* (Reason & Heron, 1995).

**a) Role Play**

Role plays or simulation techniques are a way of deliberately constructing an approximation of aspects of 'real-life' episodes or experience, but under controlled conditions, where much of the episode is initiated and/or defined by the experimenter, researcher or other inductor. Within the field of psychology, role plays are set up for a specific purpose such as exploration of issues,

experimentation with new ideas or particular therapy processes. Harré also utilizes this technique for some of these purposes. Indeed Yardley emphasizes that any methodology or any domain of inquiry, can be carried out within the as-if methodology of role play. The final question is therefore not what role play can be used but rather how can role play be best made to work? This places the inductor/ facilitator as the central protagonist whose all important skills must facilitate the *induction* of specific roles for the participants, in order that the benefits of role play be optimized.

**b) Co-operative Inquiry**

This approach is one of several methodologies which emphasizes the participation of research subjects within the research process with a view to assisting their development, both as individuals and within a collective, of effective action. In this way, the hegemonic constructs pertaining to knowledge are dismantled and the perspective of the so-called common man is placed in a central position over that of reified knowledge generated by experts. *Feminist research* (Bowles & Duelli Klein, 1983; Mies, 1993; Olesen, 1994; Reinharz, 1992), for example, asserts the need for research to honor woman's experience and explore it from the inside, often by the adoption of participatory methods. *Participatory action research* (PAR) (Fals-Borda & Rahnman, 1991; Tandon, 1989), on the other hand, works to reclaim the right of common people everywhere to create knowledge from their own lived experience while simultaneously developing collective awareness through self-inquiry and reflection. *Action science* ( Argyris & Schon, 1974; Argyris, Putman & Smithl, 1985) considers research in the service of effective action and has been developed by Torbert (1991, 1987, 1981) who emphasizes the importance of developing a quality of attention which embraces both inner purpose and external outcomes. This places transformational leadership as crucially significant in creating genuine communities of inquiry within communities of action. Co-operative inquiry subsumes these principles in an effort to sustain the following intentions with regards to the research process:

1) The person is viewed as a fundamental spiritual entity, a distinct presence in the world, who has the potential to be the cause of his own actions;

2) A person's intentions and intelligent choices are causes of his or her behaviour; they are self-determining;

3) All those involved in the research are both co-researchers, who generate ideas about its focus, design and manage it, and draw conclusions from it. Yet they are also co-subjects, participating with awareness in the activity that is being researched;

The specific methodology involved in co-operative inquiry is divided into the following phases:

a) Phase 1: a group of co-researchers come together to explore an agreed area of human activity which concludes with an agreed method for exploring the idea in action, and with devising ways of gathering and recording data from experience.

b) Phase 2: The co-researchers now become co-subjects; that is, they engage in actions agreed and observe and record the process and outcomes of their own and each other's experience.

c) Phase 3: Co-subjects become fully immersed in and engage with their experience. Through this experience they may see matters in a new light, elaborate and develop superficial understandings, diverge into new fields and discover unpredicted action and creative insights.

d) Phase 4: After an agreed period engaged in phases two and three, the co-researchers reassemble to consider their original propositions and questions in light of their experience. As a result they may modify, develop or reframe them, or reject them and pose new questions.

These phases may continue throughout the research process in constant cycles of action and reflection, and may be repeated several times.

**Adapting Traditional Methods for Discursive Psychology**

Traditional models involving numerical methods for the statistical analysis of experimental data are mostly rejected by the discursive psychologist. However, Harré & Stearns (1995) and Smith et al. (1995) clearly point out that discursively orientated research might also utilize numbers for the valid study of the human world. However, their use in Discursive Psychology is qualified and might only be implemented under specified conditions. We turn, therefore, to a brief discussion of methods which involve the discursive use of 'numbers' in psychological research before concluding this chapter.

**a) Q-Methodology**

Stainton-Rogers (1995) shows how Q-methodology can be utilized for studying a whole range of topics, but typically examples would be: 'representations' of social objects, for example, selves, others, objects; understandings, for example, about social issues or cultural artifacts such as books, movies or works of art; and policies and strategies, for example, towards social issues. What these have in common is that they are socially contested, argued about and debated; that is, matters of taste, values and beliefs about which a limited variety of alternative stands are taken. Crucial to the approach is the concept of *finite diversity* - that whenever and wherever persons are applied to a sample of elements the dialogical processes involved result not in chaotic proliferation but in the expression of several (say 4-15) ordered patternings of cultural understanding. It is this finite diversity of those patterns which is the greatest concern to Q-methodology and marks it off from most other approaches.

To carry out a Q-methodological study one must have something for participants to rank. This usually consists of between 10-100 items (a Q-set) and the activity of ranking them is known as Q-

sorting. The employment of a fixed quasi-normal distribution is seen as being most practical for data collection and yielding equivalent patterns from all. Items are either provided on separate cards or spaced on pre-provided paper or card which the participants are asked to cut up for themselves. Items are then separated into tentative partitionings of 'negative', 'neutral' or 'positive' elements. Participants are then asked to work to form a layout which matches the provided grid. Participants are not sampled but are rather chosen to facilitate the expectation of finite diversity. Sources of sampling might include: individual and\or group interviews; literature review; transmitted media output; and, the cultural experience of the researchers. In this way, Q-methodology permits us to hear those muted voices as well as the dominant ones. It fits those research questions which are concerned to hear 'many voices', whether for strictly functional or radical reasons.

Initially preliminary analysis is an exercise in constructing the hypothetical universe of propositions in the concourse of the debate. The initial pool of propositions may be three times the size of the aimed-for Q-set which will be achieved by sorting these initial propositions into increasing levels of conceptual inclusion. Once this is complete, the final Q-sort can be completed by the participants. Thereafter, the pair-wise intercorrelated Q-sorts can be subjected to Q-factor analysis. A Q-factor (or pattern) analysis mathematically reduces the matrix of correlation between the Q-sorts by assuming that they reflect the action of a small set of independent factors or components (finite diversity of interest). Q-pattern analysis can be achieved by selecting factor analytical modules from a general statistical package or a more specific Q-package. Thereafter, each Q-sort in the study is entered as data and then each Q-sort is correlated with every other Q-sort. The intercorrelational matrix is then factor analysed and rotated to simple structure. All factors which can be, are re-expressed as the 'best estimate' of the Q-sort that represents them.

The final stage of the Q-methodology study is to interpret the emergent factors. This is achieved in terms of comparisons and constrasts between the positionings of items in the reconstructed Q-sorts representing each factor. Interpretation may be aided by theory, previous research and\or cultural knowledge. Furthermore, explication by participants of the position allotted for the items as well as their reflexive correction of item positioning help refine final analyses. Similarly, findings may be interpreted in light of biographical information about participants exemplifying particular factors. It is important to note that the factors which emerge from a Q-methodological study are the result not of built-in definitions but of the sorting activity of participants themselves. Thus Q-research always has the power to surprise; no assumption about the way understandings are structured are built into the method. Similarly, research interpretations may be varied and in no way comprise 'findings' since Q- methodology simply facilitates the exploration of differing positions within de-limited discursive activity through systematic procedure.

**b) Discursive Norms and Quantitative Methods**

Egerton (1995) discusses the use of quantitative methodology to identify semantic regularities, or discursive norms, which develop to fulfil specific social functions at particular times. He contrasts this with conceptual or ordinary language analysis where the semantic infrastructure is opaque to the users since it is principally unconscious and therefore cannot be accessed via qualitative discourse analysis. It is therefore suggested that quantitative methods which identify and represent relationships; for example, correlation, factor analysis, cluster analysis, network analysis, repertory grids, multiple regression and multi-dimensional scaling, could be utilized to uncover these latent structural aspects of discourse. Important to note is that these techniques are suitable for exploring static norms but are not suitable for examining extended patterns of discourse. It is also crucial that the questionnaire or other method of data collection be constructed in a sensitive, flexible manner which will allow discursive norm patterns to emerge.

Egerton provides a useful example of factor analytic studies of the discursive norms for Northern Ireland 'troubles' victims: he attempted to uncover the strategies developed by these people in coping with the emotional pain and threat posed in news broadcasting about 'troubles' victims. Specifically, he made a tape of a mock radio broadcast conveying typical 'troubled' scenarios where people had been killed, as well as a report about the death of a cancer victim. A number of university students responded to this 'broadcast' by means of a questionnaire. This included a 28-item scale of emotion and mood words including adjectives around the poles of grief, fear, anger, sympathy, indifference and relaxation. Other open ended questions were also included which elicited participants general feelings and responses to the issues under investigation. Factor analysis revealed that respondents identified seven semantic dimensions, each reflecting clusters of semantically similar emotion words for the cancer victims. On the other hand, only two dimensions emerged for the violence victims. This study then clearly showed the existence of a powerful and unsuspected discursive norm constraining statements about emotions for 'troubles' victims.

## CONCLUSION

This chapter reviews Harré's meta-theory for psychology in terms of the proposed research methodology. The early formulations of ethogenic psychology as well as the more eclectic contributions of the discursive movement of the 1990s have been briefly reviewed in order to demonstrate the operational features of Harré's meta-theory. The methods discussed in this chapter provide a broad overview of the *possible* research methods available to the discursively orientated

psychologist while the specific methods adopted for *this* doctoral research project will be discussed in detail in Chapter 6.

Chapter 5

# A Clinical Model based on Harré's Discursive Psychology

Harré does not consider psychopathology, diagnosis or psychotherapeutic treatment to any great extent although he and his many co-authors do, however, make cursory references to therapeutic psychology and psychiatric concerns throughout their discourse. From both these references and the theoretical implications of Harré's meta-theory, an attempt to construct a possible applied clinical model based on Discursive Psychology will be undertaken in this chapter.

In order to achieve this somewhat ambitious task within the limited space available, it will be necessary to outline a conceptual schema in the following manner: isomorphic with notions supporting the development of mathematical proofs and their respective riders, the preceding chapters might be understood to outline Harré's conceptual schema at a metaphysical level and therefore represent a kind of 'proof' for (social) psychology. This and later chapters might, however, be considered a 'rider' to the original proof which includes cross-mapping conceptual permutations, both theoretically and practically, from 'proof' to 'rider'. For example, the Pythagorian proof pertaining to the nature of right angled triangles presents a host of possible theoretical permutations with practical applications in various fields, for instance, civil engineering. Similarly, clinical applications must be teased out from Harré's meta-theory through logical argument. If the mathematical analogy is to be sustained, this process should begin with specified premises and be substantiated by illustrative examples supporting distinct, logically consistent conclusions within a circumscribed universe of selected objects, principles and operations. This thesis has therefore been arranged in the following manner: Chapter 1 outlined broad philosophical concerns for traditional Clinical Psychology as well as the more radical positions countering mainstream story-lines and considered how these differing concerns might integrate Discursive Psychology interpretation at a *philosophical* level. This chapter, however, is focused on the construction of a clear, *detailed therapeutic model* based upon these arguments and those specific to Harré's theory which were explicated in Chapters Two, Three and Four. We will therefore now briefly review these philosophical concerns in relation to a circumscribed discursive field specific for Clinical Psychology. This will contain the processes involved in formulating a possible clinical model and, thereby, provide a point of departure for a more detailed exposition of therapeutic possibilities for Harré's psychology. Part II reviews three detailed case studies as illustrative examples of the theoretical permutations discussed in this chapter.

## A DISCURSIVE FIELD FOR CLINICAL PSYCHOLOGY

Reber (1985) defines 'Clinical Psychology' in a popular dictionary devoted to psychology more generally as:

> *"The area of psychology concerned with aberrant, maladaptive or abnormal human behaviour. Within the vast umbrella of clinical practices are diagnosis, classification, treatment, prevention and research."* (p. 126)

He goes on to point out that the range of therapies, clinical concerns and orientations can be, indeed, overwhelming. Reber's definitions are quoted above, therefore, in order to ground the pursuits of this chapter in what amounts to an informed common-sense understanding of the salient issues pertaining to this highly diverse and wide ranging discipline as it is *traditionally* understood. Reber's definition functions, therefore, as a form of *account analysis*, in the ethogenic sense, and represents a typical mainstream *story-line* through which the activities of psychotherapy might be understood. This is further substantiated by a host of other textbooks on Clinical Psychology. For example, Sundberg, Taplin & Tyler (1983) express a similar sentiment in connection with the extent and inclusiveness of Clinical Psychology concerns:

> *"The scope and emphasis of clinical psychology have changed over the years. ...The main trend in this constantly changing pattern seems to be that more and more kinds of people and more and more settings are included within the purview of clinical psychology. ... The constant shifts in what is being attempted, who is being served and who is doing the work naturally create confusion about the boundaries of clinical psychology."* (pp. 4-5)

These authors nevertheless distill the following fundamental areas of concern for Clinical Psychology, in its broadest sense:

- Clinical *assessment* including psychometric evaluation, diagnosis and classification;
- Clinical *intervention* across system levels, from individual to community levels including *prevention*;
- *Research* into Clinical Psychology.

It is indeed necessary to incorporate traditional Clinical Psychology into Discursive Psychology if the goals of this thesis are to be realized; the current story-lines predominantly used in the field of Clinical Psychology need to be embraced if conventionalization is to occur at all. We will therefore attempt to map Harré's psychology in the manner outlined above to 'traditional' issues pertaining to 'aberrant, maladaptive or abnormal behaviour', in relation to the clinical practices of assessment,

diagnosis, classification, treatment and prevention. Through this process the following goals for this chapter will be pursued:

1) To present Harré's psychology as an overarching meta-theory which might facilitate an understanding of the underlying generative mechanisms supporting therapeutic resolution of clinical problems if Discursive Psychology principles, techniques and formulations are applied to these traditional concerns;

2) To show how central ideas, methodology and techniques from the predominant traditional therapy schools identified in Chapter 1 with a Positivist meta-theoretical orientation; that is, psychiatric, psychoanalytic (dynamic), cognitive-behavioral, humanistic-phenomenological (client-centered, gestalt, existential) approaches can be integrated into a discursive clinical psychology;

3)To integrate the therapeutic strengths of Social Constructionist perspectives; that is, the principles involved in various systems-theoretical therapeutic approaches (strategic, structural, Milanese, eco-systemic), narrative therapy and therapeutic deconstruction analysis into the discursive clinical psychology model;

4) To consider the possible clinical applications of Harré's psychology for intervention at different levels of the human ecosystem; that is, at individual, dyadic and familial levels. These will be discussed in some detail, while the community level (including prevention) will only receive cursory attention given the specific case study focus on mainstream Clinical Psychology activities.

Hopefully, this will not be yet another new approach to further overwhelm and confuse, since an understanding of the *meta-theoretical* implications of Harré's psychology is the ultimate pursuit of this doctoral project and should have broad relevancy for both traditional and more radical forms of Clinical Psychology in relation to both theory and clinical practice. We will now discuss the Clinical Psychology 'rider' to Harré's metaphysical 'proof' for (social) psychology in detail in terms of the traditional formulation of the clinical activities already outlined. Through this endeavor, a sense of the *possible* workability of these meta-theoretical concerns for everyday, practical psychotherapy will be illustrated.

**Clinical Assessment, Diagnosis and Classification**

In order to ground this discussion in the realities of clinical work and all the attendant implications thereof, an illustrative example coined by Harré & Gillett (1994) will be quoted in detail, while the clinical aspects of this example can be unraveled and developed for the purposes of this chapter. Other illustrative examples by the two co-authors will be cited and dealt with in similar fashion during the course of the argument.

In an effort to demonstrate Discursive Psychology theory as praxis in light of its central postulates, the case of "George" is discussed by the authors. Both the conceptual points as well as the example are quoted below:

> *"In any discourse there are significations that are validated and others that are not ... which makes a variety of responses available to a person ... the normative and evaluative structure of a discourse may constrain the ways in which a person acts. Consider the following case.*
>
> > *George feels inadequate to cope with the stresses and challenges he meets daily. But he feels that he must be a successful man so as to be able to respect himself and command the respect of his others, particularly his wife. What is more, the cultural discourse to which he belongs tells him that his success is in his own hands, that a real man is in charge of his own life. However, he fails in a number of ways, in his schooling, in his job, in his own perception of how his wife and his parents see him. Frustration, hostility, aggression, and ultimately violence result from the mismatch and he falls into a pattern that brings him into conflict with the law, breaks up his family, and blights the life of his children."*
>
> *Now, what can we say about George? He has organized his world in terms of certain meanings. They include being a real man, being competent and able to cope with his life, being successful. When it emerges that there are things he cannot cope with, that he is not as he portrays himself to be, these meanings provoke a certain kind of reaction. He sees himself as hurt or threatened and frustrated in what he would like to do and be. He reacts to this in ways that are validated within his discursive context. In certain contexts he would feel all-consuming shame and perhaps see no alternative but to destroy himself. Instead, he develops aggressive responses, which he then turns on others. The conceptual connections available within the discursive context he inhabits make his responses likely but do they make them inevitable? Is he free to react differently? The answer, as for almost all important questions, is "yes and no"".* (pp. 23-24)

The limits of personal freedom and agency are clearly the authors' concern here, but what of the clinical implications for the psychological problems that this example suggests? Indeed a number of central issues emerge on a closer clinically orientated analysis. We can identify four distinct problem areas which might inform the levels at which clinical intervention might take place, broadly speaking :

i. Individual level: George himself
ii. Dyadic level: George's marriage

iii. Familial level: George as parent to his children

iv. Community level: George's social context

Given the above information, George, at the individual level might be diagnosed and classified according to the DSM-IV as suffering from a variety of clinical problems if he were presented for treatment towards the end of the processes described by the authors. While a Social Constructionist understanding of psychiatric diagnosis might criticize this perspective, it is important to remember that more recent editions of the DSM have focused on symptom classification through description and do not imply explanatory causes. Essentially the manual seeks to provide an interdisciplinary *vocabulary* of clinical problems often presented to clinicians for treatment. The philosophical implications of psychiatric discourse and other nosological systems were discussed in Chapter 1 and for the moment, therefore, we might simply restrict ourselves to a mainstream psychiatric discursive analysis in order to translate Harré's illustrative example into clinical terms for the purposes of this chapter. This is especially pertinent if this doctoral project is to have any relevance whatsoever for Clinical Psychology as it is practiced here and now; it is crucial that the current clinical models are incorporated into a potential discursive approach since without this interface, no dialogue is possible and the discursive clinical project is doomed before it even begins. We will, however, consider the real, practical implications for George and the social structures surrounding him when a psychiatric discursive gaze is chosen and applied to life problems.

Although Harré and Gillett do not provide much information on George's life situation and it might therefore certainly be argued that there is far from sufficient information to warrant a full clinical diagnosis, this exercise is intended merely to illustrate a potential reconcilability between Harré's Discursive Psychology and Clinical Psychology as it is currently practiced and nothing further. The clinical picture, or story-line, if you like, for George, his spouse and their off-spring might therefore be categorized in part according to the latest psychiatric manual, the DSM-IV, in terms of the multiaxial assessment. This involves a bio-psycho-social assessment of the individual along several axes, each of which refers to a different domain of information. This is intended to inform a potential clinical plan and treatment and also predict some salutary outcome. There are five axes included in the DSM-IV multiaxial classification and are categorized as follows:

| | |
|---|---|
| Axis I | Clinical Disorders |
| | Other Conditions That May Be a Focus of Clinical Attention |
| Axis II | Personality Disorders |
| | Mental Retardation |
| Axis III | General Medical Conditions |
| Axis IV | Psychosocial and Environmental Problems |

Axis V        Global Assessment of Functioning

Although it necessary to extrapolate, perhaps fictitiously in some regards, from the scant description of George's problems, a little imagination might create an associated clinical picture for George using this classification system.

**A DSM-IV Construction of George's Life Problems**

An individual clinical assessment of George himself may well contain depressive features as well as so-called personality characteristics, while psychosocial factors must also play a significant role. A full diagnosis might read as follows therefore:

Axis I: 300.4  Dysthymic Disorder

Axis II: 301.83  Borderline Personality Disorder

Axis III: Deferred

Axis IV: Unemployment; family estrangement; arrest

Axis V: GAF = 16 (over past year)

Although the clinical features of Dysthymic Disorder are similar to those for a Major Depressive episode, George's chronic self-esteem problems appear better accounted for by the former diagnosis since the DSM-IV maintains the following in relation to the hypothesized Axes I classification for George:

> *"Several studies suggest that the most commonly encountered symptoms in Dysthymic Disorder may be feelings of inadequacy; generalized loss of interest or pleasure; social withdrawal; feelings of guilt or brooding about the past; subjective feelings of irritability or excessive anger; and decreased activity, effectiveness, or productivity. ... Dysthymic Disorder may be associated with Borderline, Histrionic, Narcissistic, Avoidant and Dependent Personality Disorders."* (pp. 346-347)

While George might certainly be suffering from an excess of the 'blue' emotions (Harré, 1983) given his pervasive experiences of failure, which might warrant the diagnosis of a generalized Mood Disorder, his aggressive responses towards others are not fully accounted for by this diagnosis alone since his irritability or excessive anger is primarily understood to be experienced subjectively and not interpersonally. It therefore seems appropriate to employ the Axis II category, Borderline Personality Disorder, to further interpret Harré's description of George through the gaze of mainstream Clinical Psychology and psychiatry.

A Personality Disorder is described in the DSM-IV as

> "… an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has its onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment". (p. 629)

Borderline Personality Disorder is described specifically as

> " …a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins in early adulthood and is present in a variety of contexts." (p. 650)

A clinical diagnosis of Borderline Personality Disorder however must rely on the presence of five or more of nine specified psychosocial criteria. George might therefore be diagnosed as exhibiting symptoms of the following five criteria:

i. Criterion 2: "a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation";
ii. Criterion 3: "identity disturbance: markedly and persistently unstable self-image or sense of self";
iii. Criterion 6: "affective instability due to marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)";
iv. Criterion 7: "chronic feelings of emptiness";
v. Criterion 8: "inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)." (p. 654)

Harré clearly points out however that George is acting within the constraints of his culture, as a function of the discursive practices that surround him through interpersonal relationships. How then can one reconcile the DSM-IV notion that Personality Disorders are *defined* by behaviour that runs counter to culturally acceptable behaviour within the proposed discursive interpretation of George's difficulties? It seems possible however that a discursive interpretation might subsume DSM-IV ideas and account for any apparent anomaly from within its theoretical formulations. That is, Harré mentions that George attempts to construct a personal and social identity that expresses his position as a 'real man', and this informs the principal thrust of his moral career. He expects himself to be successful in a number of significant social situations and, more especially, he believes that this endeavor is in his own hands, that any success or failure must be attributed to himself. In this manner he is fully congruent with the cultural beliefs within which he is located. When he fails, however, there is the threat that the discursive assumptions surrounding him may position him as contemptible

especially if he passively accepts his position as 'a failed man'. George however chooses to construe his contemptible position from an alternative 'real man' vantage point and adopts a violent, aggressive social persona which defends his wounded moral career since being violent and aggressive is something a 'real man' might also do. Ideally, however, the example suggests that a truly successful man will not have to resort to this form of social honor although the discursive context provides recourse to social honor in this form should it be necessary and the individual so chooses.

Unfortunately life is more complicated than this and from the perspective of various positions within the discursive contexts surrounding George, his violent compensatory efforts are simultaneously construed as contemptible, in his roles as father and husband, for example, as well as from the perspective of the law. Moreover, it is likely that these contradictory elements might indeed maintain his behaviour: from one position George seeks to repair his flawed social and personal identity by means of certain violent activities which might support this project and yet these very reparative efforts disrupt any reparation from alternative positionings, *simultaneously* - in effect George can never win and yet fights on regardless, every reparative act leading to further experiences of failure. We might imagine a situation where George is referred for psychiatric evaluation when legal authorities intercede after a violent episode, perhaps one of many, at a local public house. From the positionings of the legal fraternity, the social welfare, the psychiatric community and indeed even alternative positions within George's own community and family, he indeed is conducting himself in counter cultural fashion, yet he is also attempting to manage a moral career as a 'real man' within available discursive metaphors. This argument it seems can absorb the DSM-IV construction of a 'personality disorder' yet preserves the central tents of Discursive Psychology.

These formulations are reinforced in Harré's discussion of Multiple Personality Disorder (MPD) (Harré, 1998): this clinical syndrome is viewed, firstly, from the perspective of the pragmatic implications of everyday life, where multiple presentations of self, that is, personal and social identities, are indeed adaptive given myriad positionings and diverse discursive contexts within which individuals move. MPD is therefore re-interpreted as manifesting acts of personal agency; the 'personalities' do not therefore 'inhabit' a particular individual's body, but rather emerge as a function of their usefulness as discursive maneuverings. This type of discursive practice, however, is defined as pathological by psychiatry. Harré maintains that this is a result of the grammars and metaphors implicit within psychiatric discourses; that is, ' psychopathology' only exists where "Pathological Worlds" are brought into being through contingent story-lines, speech-acts and belief-systems - it is through these mechanisms that discourses of normality and abnormality are created.

From a psychiatric position, therefore, George's behavior is clearly maladaptive, for both himself and those who surround him, especially his family. Moreover, and more importantly, his behavior is inflexible across a number of discursive contexts and does not promote adjustment in terms of these contexts or in terms of George's personal identity or the management of his social identity, in *discursive* psychological terms. Therefore, his behaviour shows maladjustment from the position of Discursive Psychology as well. A discursive psychological view of psychopathology will, however, be more fully discussed in the next section of this chapter.

The example does also suggest that Axis IV psychosocial and environmental problems exist and, further, clearly indicates that these might be a function of self management problems and not simply due to the vagaries of chance. These include obvious problems with the primary support group, occupational problems as well as problems related to interaction with the legal system. In addition, it is possible that educational, housing as well as economic problems might also exist. An Axis V score would therefore not be very favorable especially considering that in a Global Assessment of Functioning review any "danger of hurting self or others" (p.32) receives a very low rating in the DSM-IV. It is necessary however to integrate this individual psychiatric construction within a broader system if the discursive elements of this analysis are to be developed. We will therefore consider now the implications for the other system levels identified above.

**The Eco-systemic Implications of George's Problems**

George's marriage is described as problematic in the example, although very little other information is provided. The example however does suggest that George is the cause of the problem. Indeed his own constructions position himself as blameworthy, and he assumes that his spouse perceives him in the same manner. These beliefs, we are told, comprise his social identity; these constructs or generative mechanisms therefore organize and motivate his aggressive behavior. A discursive analysis cannot, however, isolate the individual from the social context and this example needs to be understood in light of Harré and Gillett's efforts at explaining the notion of personal freedom and agency. Another example however does explicate the mutuality involved in dyadic problems typically brought to marital therapy; the intersubjective locale and the discursive limitations within the dyadic context are explained more comprehensively and may be synthesized with George's issues, given a little poetic license.

> *"We have already suggested that the notion of the unconscious is best understood in relation to what can be affirmed and validated within a discourse. There are meanings justifiably assignable to what a person is doing that are either poorly mastered or incommensurate with the values arising from that person's discursive self-location as a conscious agent. These*

*meanings have a validated use but it is not available to that very person, for reasons we might come to understand by appreciating the rest of his or her self-construction. The person whose actions evince these significations will therefore neither be in control of nor fully responsible for the things they are doing because they cannot adequately locate their content. For instance, a young woman who questions the way her partner is managing their money might not understand why he cannot discuss this with her and he may regard her as being hostile to him. She may not consider this questioning as touching his worth as a person whereas he does. We would probably only come to understand his reaction by looking at the discourses that have determined his self-conception."* (p. 142)

Although the authors themselves do not link this directly with the example of George, it is not difficult to see how the two examples might interact conceptually; that is, the former example outlines George's personal project at the individual level, while the latter indicates how unconscious discursive structures might maintain marital problems at the dyadic level given the mutual lack of awareness of those discursive positionings available to each spouse at the individual level. Indeed if George were the husband in the second example, any interrogation by her about his financial success might be construed as highly threatening since George believes that as a 'real man', success is in his own hands and he already perceives himself to be a failure within his own rule-system and assumes that significant others such as his wife harbor the same misgivings. She, on the other hand, may simply be attempting to assist her husband with the financial pressures of their mutual life together as a couple. It is possible that every effort made by the wife at improving their position would be met by aggression or violence; the more she tried to improve matters the worse the situation would become. Unfortunately, neither party would be aware and conscious of the underlying generative mechanisms supporting this dismal existence.

This explication suggests that it may be dangerous to uncritically adopt the psychiatric discourse outlined for George at an individual level. If, for example, he were diagnosed as is proposed above and treated with medication or through traditional individual psychotherapy, his wife would still be quite unaware of her contributions to the mutual cycle of conflict. An even more pressing danger, however, is that George may be cast into the role of 'psychiatric patient' by others and may or may not choose to assume this positioning; thereafter all marital conflict could be explained in these terms. The conflict would continue whether or not George accepted the role since the underlying process would remain unaltered, possibly becoming progressively worse as George was constructed into an ever deepening pathological position, ever more fixed, inflexible and unresolved. In this manner, George may begin a moral career as a psychiatric patient where his various failures were explained by others as well as himself as symptomatic of his psychiatric *disorder*. Indeed if this were

to happen, George's situation could not possibly improve since his very social and personal identity would depend on his position as psychiatric patient; any healthful change would threaten that position.

On the other hand, if the psychiatric diagnostic system is used simply to organize complex material pertaining to life problems at a descriptive level, a systems-based discursive orientation might direct clinical work towards working at both the individual and dyadic level, ensuring that psychiatric labeling does not interfere with ameliorative efforts. In short, psychiatric classification and diagnosis might simply inform all parties concerned that there indeed is a problem from various discursive positionings with one or more members of a system; that is, 'diagnosis' functions as a social 'action' in order to facilitate a social 'act', thereby granting rights and privileges (as well as restrictions) to the individual in the patient role. Thereafter it would be possible to focus upon the underlying generative mechanisms supporting these symptoms, while efforts towards improvement might be directed at the discourses and processes maintaining the symptoms - the emphasis would be on the latter and not the former. In this way, it might be possible for the clinician to balance a Realist orientation towards the actual existence of life problems as conceived by the psychiatric community at any given time (these constructs may change) yet preserve a sensitivity towards the patient's social construction of life problems from their own point of view.

The third level at which problems arise in George's life is within his family system, with regards to his relationship with his children. It is possible that one or more of his children could be referred for counseling due to school failure, behavioral or anxiety related problems, for example. Again in each case it would be feasible and indeed useful to classify the problems according to the DSM-IV classification system but only for the purposes of description, communication amongst clinicians and defining the problem as a social act, as worthy of treatment. A full assessment of the problems confronting the child would necessarily involve an understanding of the parental system and its impact on the children as individuals. Harré and Gillett, for example, quote a situation which again might resemble the kind of problems with which a child in George's family may be confronted.

> *"Consider the example of a child who is taught by implicit evaluations to regard an uncle as 'a hard man'. From another perspective and in the eyes of many persons, this uncle is a weak man who tends to shift his stance with shifts in the opinion of others and is not really "hard" except in his expressed opinions. The failure to act "hard" toward others undermines the actual meaning of the signification and yet the implicit evaluations suggest that it should be acted on. This leaves the child, as it develops and tries to locate itself in relation to discursive meanings, with an impossible task in a world where those meanings are, in general and necessarily, closely tied to manifest activity." (p. 141)*

Would George's son perhaps find himself in a similar position with regards to being a 'real man'. How is he to be a 'real man' since he lacks a model or training in its actual use yet it is clearly a value within the family unit. It is possible that he might develop Conduct Disorder related problems in efforts at discovering his limits as a 'real man', or on the other hand, may exhibit symptoms of Mood Disorder by being withdrawn and depressed, or suffer from Generalized Anxiety Disorder given the pressure of the contradictory positionings he must learn to reconcile in his personal and social identity. He may even choose to obscure the dilemma by adopting a counter position which may manifest in some form of Gender Identity Disorder, for example. On the other hand, the ambivalent construction of the father as a 'real man' may predispose a female child towards developing phobic anxiety responses in situations where other adult males were present, or separation-anxiety from her mother since male figures might be considered untrustworthy. These adjustment problems may of course inhibit her progress at school, creating associated learning problems. All these possible symptom manifestations could be referred to a clinician for treatment. A discursive analysis of children's problems would therefore necessarily include an understanding of the parental problems, and the unconscious belief-systems that would be maintaining conflict within the family.

At the community level, George's situation might not be considered unusual. It is certainly possible that compensatory social and personal identity management efforts in the form of violent displays may be commonly endorsed in some of the community contexts where George is located. All the other symptom manifestations could also be quite common within a circumscribed social grouping. These may, however, be tolerated by a community who were simply not aware of the manner in which their systems of honor were inhibiting their overall optimal adjustment. Thus the assessment of factors maintaining clinical problems might consider this level in addition to the other three. We are reminded here of ethogenic studies of violence amongst supporters of football conducted by Marsh et al. (1978), were belief-systems surrounding aggressive displays existed within a wide community network.

## DISCURSIVE PSYCHOLOGY: DIAGNOSTIC ASSESSMENT

From the forgoing discussion it seems clear that psychopathology as it is traditionally understood in psychiatric circles might well be subsumed into a Discursive Psychology perspective and understood from multiple positions and levels. It appears, however, that Discursive Psychology itself implies the possibility of maladjusted ways of being in the world for individuals and groups of people within its own conceptual parameters. In order to illustrate the presence of both of the above assertions in

Harré's discourse, a useful quote from Harré and Gillett's discussion on discursive limitations and personal adjustment will begin an effort to define psychopathology from a discursive perspective.

> *"As human beings extend their discursive skills (not merely the verbal expression of those skills), so they expand their consciousness; that is, they extend the range of matters to which they can attend and which they are aware.*
>
> *We can illustrate this with reference to the life experience of many who are diagnosed as having borderline personality disorder because of a history of petty violence, failed relationships, and other disorderly behavior (sometimes punctuated by dramatic episodes such as suicidal gestures or outbursts of sustained and spectacular aggression). When talking to such individuals, one finds that they are poor at articulating or understanding the events of their lives and the relationships amongst them. They tend to have very limited discursive context within which to negotiate and elaborate their responses to life events. Their discourse is dominated by words and expressions (many of which are unprintable) like these: "I'll show them all," "putting people down," "getting back at them," "can't be bothered," "I don't know," "see if I care," and so on. All are limited. They indicate lack of insight and direction, particularly in interpersonal situations. This lack of depth and richness in the discursive content of their subjectivities translates into a human and relational lack in their lives in general.*
>
> *The case of these unfortunate and limited subjects illustrates the fact that consciousness is the subjective springboard of agency. One cannot do that of which one cannot conceive and one cannot conceive of content for which one lacks the discourse-based skills. This is particularly true when the topic at the center of consciousness is oneself."* (p. 175)

Does this material as well as the other examples discussed above suggest that Harré has a position on psychopathology? Two possibilities seem to exist:

- firstly, it is possible that where a decided paucity of personal agency is displayed by an individual through lack of consciousness and relatively few or very limited discursive skills, non-optimal psychological activity may be said to exist. Perhaps one might define this as 'psychopathology', especially where harm to self or others is apparent, as in the case of George;
- secondly, where a moral order positions people as psychologically ill, with concomitant rights and obligations and idiosyncratic emotionologies, then psychopathological worlds can be deemed to exist with their own rule-systems, constraints and beliefs, for example, psychiatric discourse.

Are these two perspectives reconcilable with one another? It does appear possible to merge these notions into a comprehensive formulation if one considers "psychopathology" as *social* behavior.

That is, where a discursive moral order system involves pathological constructs such as the psychiatric label of Borderline Personality Disorder, for example, this may be *simultaneously* understood as:

a) The discursive limitations of individuals so diagnosed who act meaningfully within their systems of reference; the psychiatrist and patient simply adopt positions in relation to each other, much like a husband- wife, child-parent, employer-employee, or any other social dyad.

b) The position of patient may be the result of a lack of discursive skills and agency on the part of the "pathological" individual.

c) A lack of available significations within the social context will maintain the status quo since "pathological" individuals are limited by the constraints of the discourses surrounding them.

d) A "pathological" person may be understood as acting with personal agency, although these creative acts are deemed pathological by other actors within the moral order, from alternative positionings.

This formulation therefore contains both a Realist and Social Constructionist understanding of psychopathology albeit in Discursive Psychology language, and might certainly subsume traditional notions of psychological maladjustment which may cause undue distress for both individuals and groups of people. Two core ideas seem to emerge, therefore, which form a kind of conceptual pivot about which a Discursive Psychology reading of Clinical Psychology might turn; that is, the quintessential position of *self-consciousness* as the precursor to increasingly competent acts of agency and the importance of possessing and developing the necessary discursive *skills* for the articulation of life projects. It seems necessary, therefore, for the discursively-orientated diagnostician to focus on assessing the relative presence of the following aspects once a case has been referred for clinical intervention:

1) The prominent significations about which an individual, dyad, family, community or other grouping bases their personal and social identities, and the articulation of their moral careers;

2) How these significations are maintaining the referring clinical problems;

3) The extent to which the relative lack of skills is preventing people from formulating better adjustment options for the articulation of their moral careers.

We turn now to a consideration of the possible assessment instruments and procedures which may be useful for the discursively orientated clinician who must learn to identify the idiosyncratic constructions existing within the discursive systems referred for treatment.

**Discursive Applications in Psychometric Testing**

All of the research methods and general methodology discussed in the last chapter can be usefully applied to clinical assessments in an effort to deconstruct the belief-systems and their interactive processes which may be ultimately responsible for the generation and maintenance of symptoms; for example, Martin (1988) demonstrates how the client might self-instruct through ethogenic research processes during individual counseling, while Tunbridge (1994) indicates how ethogenic research strategies might enhance conflict resolution between pupils and teachers in the schooling context. Principal amongst these techniques is the Role Construct Repertory Test (Kelly, 1955) which focuses on the way that people construe those who are closest to them. In this test, the person as psychological subject could list their family members or any other significant people in their life and then be asked to think of some way in which two of these people would differ from a third. The dimensions of distinction would be personal descriptors; relevant contrasts such as intellectual \ boring, loving \ unloving, aggressive \ gentle, musical \ nonmusical, educated \ uneducated might be examples. Each subject must then rate all of the people on their list on each of the constructs they have defined. Harré and Gillett maintain that this is of great interest to discursive approaches for several reasons:

> *"1. The participant's own ideas are the basis of their assessment.*
>
> *2. The constructs are defined by reference to real people to whom the participant relates in everyday discourse.*
>
> *3. The interpersonal world of the participant is used to explore their own applications of their constructs and to provide the investigator with a framework against which to try to understand the judgments and classifications that that individual makes."* (p. 139)

These three aspects might therefore be applied to any assessment technique in order to ascertain whether or not the method meets the necessary self-constructive criteria for a discursively orientated analysis. In general, therefore, Harré maintains that it is quintessentially important to incorporate the subject's self-accounts in their own assessment:

> *"But, unlike Freud, Kelly did not to invalidate the self-conception of the subject to discover the nature of (their) ... psychic problems. In fact, he says, "If you do not know what is wrong with a person, ask him (or her), he (or she) may tell you". (p. 138)*

All the other techniques used for ethogenic and discursive research can be utilized for clinical assessment it seems, since all adhere to the three basic assumptions which constitute the primary criteria for Discursive Psychology validity. In clinical work, the "research" focus might simply be re-directed towards understanding how the symptomatic behavior is generated and sustained by the speech-acts, story lines and positionings under investigation through ethnographic observation,

account and action analysis, autobiographical techniques, and so on. Furthermore, if these criteria are adhered to, it may be possible to adopt, develop or adapt any assessment instrument or clinical interview method to facilitate the explication of the moral order story-lines and the various positionings within the patient's discursive contexts in relation to typical traditional symptomology. Indeed, traditional psychometry could assist in helping subjects who seek assistance with their life problems to develop increasingly competent forms of personal agency through both increasing levels of self-awareness; that is, both self-consciousness and self-knowledge, and by locating areas for the optimal development of life skills. Both of these forms of self-development will, in turn, assist individuals in the articulation of their personal projects and moral careers as social and personal beings. The possibilities for usefully integrating traditional psychometric instruments and assessment procedures with more purist ethogenic and discursive techniques are endless and may be limited only by the creative limitations of the clinician. The case studies which follow in Part II of this doctoral dissertation will explicate examples of these processes in detail through illustrative demonstration.

It is important to point out that in a discursive clinical approach, assessment and intervention would in reality occur concurrently; that is, the use of any assessment instrument, interview or technique would necessarily involve intervention simultaneously since the speech acts involved in assessment already reconstruct the subject through implicit story-lines and patient-therapist positionings. This would mean that completing a Role Construct Repertory Test, for example, would in itself begin a process of self-reflection in the subject. This in turn could have implications for acting with increased levels of personal agency through the identification of implicit generative mechanisms of self. Any of the other traditional psychometric tests which were discursively congruent and administered according to the suggested integrative procedures could also begin reconstructive, agential activities. Both testing formats, purist as well as hybrid, would promote the subject's access to the artifacts of personal consciousness and the fact of self-construction; that is, self-knowledge and self-consciousness, respectively. These factors alone have enormous consequences for the articulation of personal agency and the enhancement of quality of life as constructed by the patients themselves.

Most traditional assessment instruments however are modeled off Positivist paradigms and draw on normative information, expert knowledge and predetermined constructs about which individuals are rated on variables such as relative degree of psychopathology or neurological anomalies, personality characteristics, interest and value profiles, intellectual and perceptual skills as well as ego strength, amongst many others. Clearly these formulations do not meet the criteria suggested by a discursive approach to psychological assessment in relation to the idiosyncrasies of the discursive practices in various discursive contexts and their intrinsic discursive diversity. Does this therefore mean that the discursively orientated clinician should simply throw out traditional assessment instruments in favor

of discursive methods? This could mean, unfortunately, that the baby is thrown out with the bath water and, moreover, does not constitute a *reconciliation* between Positivist and Social Constructionist ideas in Clinical Psychology. It is therefore suggested that while *self-constructive* accounting efforts on the part of the patient during assessment will always be preferred by the discursively orientated clinician, it does seem feasible, however, to consider using traditional psychometric instruments, at least in part, when formulating a clinical picture even during Discursive Psychology assessment. It is, however, important to decide upon those traditional Positivist and Social Constructionist clinical assessment approaches which could be usefully integrated with Discursive Psychology methodology; that is, in terms of both the processes involved in the integrative project and differentiating those tests or groups of tests that are clearly contradictory to the all important meta-theoretical principles of Discursive Psychology. We will consider both of these possibilities below.

**Integrating Traditional Psychometric Tests with Discursive Psychology Methodology**

- Projective Techniques

This line of argument could suggest, it therefore seems, that certain traditional projective techniques, for example, the Thematic Apperception Test (Murray, 1938) or the children's version thereof could be used creatively within the principles outlined for valid Discursive Psychology assessment. Subjects' responses, for example, might be read back to them by the clinician and may generate further discursively orientated discussion and questioning. The clinician may also, for example, link subjects' responses to other information generated during assessment which might encourage further discourse. In the case of children, for instance, familial beliefs deconstructed using more purist ethogenic methodology might be cross-mapped to stories or discursive responses elicited from the children using this traditional projective technique. Other projective techniques such as the Rotter Incomplete Sentences Blank (Goldberg, 1965) could also be usefully combined with discursive principles along similar lines. This is preferable to the clinician interpreting the information according to Realist assumptions, psychoanalytic formulations, for example, which, from a Social Constructionist perspective, at least, would be understood as an invalid rhetorical re-description of subjects' responses in terms of psychosexual conflicts and the like.

- Psychological dysfunction identification

Other Positivist techniques including assessment inventories such as the Minnesota Multiphasic Personality Inventory (Hathaway & Meehl, 1951) or its more recent isomorph, the Millon Clinical Multiaxial Inventory (Millon, 1977), may be useful in identifying the presence of psychopathology without necessarily explaining the mechanisms maintaining the diagnosed problems. From the psychiatric position, therefore, the possible presence of anxiety, psychosis or personality disorders,

for example, could be usefully identified. This should, however, lead to a further discursively orientated investigation with the subject and significant members of their social world in order to ascertain perspectives on the so-called abnormalities from alternative positionings. At all times the clinician should be fully aware of the constructed nature of the test categories and process and must approach the procedure from a self-reflexive, self-critical position; the subject's own accounts must be taken as seriously as the test results.

Similarly neuropsychological tests such as the Luria-Nebraska Neuropsychological Battery (Golden, Moses, Fishburne, Engum, Lewis, Wisniewski, Conley & Burg, 1981) may be useful for identifying abnormalities of neuro-physiology and functioning. Indeed organic pathology may have enormous implications for general adjustment and the articulation of personal agency or the development of appropriate, useful discursive skills; limitations should therefore certainly be identified by the discursively orientated clinician. These could, however, be understood in light of the discourses surrounding the afflicted individual, both in relation to the dysfunction as well as more broadly in terms of overall life style adjustment (Luria, 1973).

So too standard intelligence tests as well as aptitude appraisals might be useful in establishing whether mental handicaps or learning problems exist, or which areas of intellectual functioning according to scatter analysis are stronger and weaker for individuals. These tests could be validly applied given the fairly uniform discursive content of standardized scholastic pursuits across the globe (Tulviste, 1991). Alternative measures of intellectual functioning such as the assessment of learning potential (Feuerstein, 1979) or Sternberg's systemic, ecologically orientated analysis (Sternberg, 1989) could also be used effectively. Both these as well as standardized intelligence and aptitude tests might, therefore, prove useful for discursive attempts at formulating a meaningful clinical picture for the optimal development of personal agency at the individual level, certainly within the confines of the social metaphors and cultural repertoires of the Western individual, of which 'Clinical Psychology' is most definitely a part.

Nevertheless, any use of these pre-structured tests could end up constructing the subject in problematic ways and obscuring the discursive clinician's task of trying to identify the *specific* belief-systems and personal constructs underlying individuals' and their significant others' behaviour. It does, however, seem possible to use some of these tests diagnostically without allowing their pre-determined constructedness to obscure idiosyncratic aspects of the assessment. In this manner, it may be possible to add useful, new information to clinical discursive assessments which may assist in promoting healthful change in discursive terms. For example, both the MMPI as well as the Revised Wechsler Adult Intelligence Scale might be administered in George's case. This might establish his

current ~~level of intellectual~~ functioning as well as ~~his relative mental health~~ status compared to other adults on indices such as anxiety levels, for example. Their validity as useful tests would of course vary as a function of the relative cultural congruence of the original test population and George's world. Nevertheless, using tests to assess anxiety levels and/or cognitive distortions could indeed be useful in George's case since Harré & Gillett point out that anxiety and guilt, as well as distortion can occur within an individual's personal construct system. Psychometric testing might help the clinician identify some of the elements that were interfering with optimal adjustment. George may, for example, find it difficult to identify why he has failed in so many contexts over his life span. This unknowing position may generate distress in and for itself. In this regard Harré writes:

> *"Problems arise when an individual's construct system does not allow adequate adaptation because it fails to anticipate events or to assimilate them to other experiences in ways that allow organized action. This leads to maladaptation and distortion in one's constructs. One might, for instance, 'un-name' a construct (make it "pre-verbal") or submerge one pole of the implicit contrast involved in a particular construction of events ... This does lead to various tensions of various kinds. For each person, there is a core of constructs that defines his or her cognitive essence as a self-conceived individual, and significant departures from this in order to accommodate experience lead to guilt - a person is aware of not being who he or she sees him- herself as being. A person might, in another case, find that events escape adequate construction and that they cannot cope so that anticipations fail and the capacity for adaptive action is lost. In this case, one will experience anxiety."* (p. 137-138)

- Sociometric assessment

There is no reason, moreover, to maintain an individual testing focus and sociometric tests might assess family interaction and family environment, for example. One such sociometric test, the Family Environment Scale (Moos & Fuhr, 1982; Moos, 1975, 1974), has ten subscales covering such topics as family cohesiveness, conflict, achievement orientation, moral-religious emphasis, and control. The answers of all the members in the family can be averaged to get a family profile, or differences among family members in their perceptions of the family can be studied. The Bene Anthony Family Relations Test (Bene & Anthony, 1978), a psychodynamically oriented test, could also be used to illicit familial constructions from individual members including even very young children and integrated with discursive techniques as previously discussed.

Still larger systems might also be assessed such as organizations and communities. Social climates of schools, industries, and organizations can be studied by obtaining reports from participants on the characteristics of the system of which they are part using sociometric measures. For example, sociograms, derived from asking sets of people who know each other well to indicate others with

whom they would like to do something, could be useful. Preferences for roommates in a college dormitory might be an object of interest for investigating adjustment among adolescents with presenting problems, for example. Popular and isolated individuals can be identified in this manner (Sundberg, 1977) and could lead to further discursively orientated analyses. Other sociometric techniques such as social network and support system identification (Sundberg et al., 1983), or situational tests such as the Leaderless Group Discussion (Bass, 1954) already integrate many of the ethogenic principles within their methodologies while still working with rating scales, checklists and even quantitative counts of words on a transcript of the interaction, all of which tend to model more traditional, Positivist psychometric approaches.

**Incongruent versus Congruent Positivist Approaches**

Certain tests modeled off typical Empiricist methodological principles such as trait-factor personality analysis, for example, might be too rigid and ethnocentric in their constructs to be of use to the discursively orientated clinician and may be best discarded completely. That is, factor analysis as a statistical procedure for identifying clusters of items that go together has been widely used in personality inventory construction, such as the Sixteen Personality Factor Questionnaire developed by Cattell (Cattell, Eber & Tatsuoko, 1970; Karson & O'Dell, 1976). Unfortunately, the initial choices for grouping clusters are, however, always ethnocentrically bound; that is, where proper discursive procedures are not used initially, the results will always necessarily be discursively invalid. Other personality tests may also have questionable utility for the discursively oriented assessment, for example, rational or theory-based approaches which start with a preconceived set of concepts about personality since items are written to fit the theory and grouped into scales on the basis of these theoretical concepts. The Allport-Vernon-Lindzey Study of Values, for example, was developed from Spranger's theory (Sundberg et al., 1983) about the six types of human value orientation - economic, political, theoretical, aesthetic and religious. The test is written in such a way that respondents must choose among the items that express these various values. This involves both factor analysis and rational-theory based approaches and could easily fall into ethnocentric tautologies which would not be any use at all to the discursive clinician. On the other hand, alternative test construction approaches such as the group contrast method used for the construction of assessment instruments for personality, interests and values, seem more in line with discursive principles. The MMPI, for example, was constructed on the basis of responses of previously identified subjects suffering from various psychopathological disorders contrasted with symptom free candidate responses. This approach seems to accept the reality of the psychiatric discourses surrounding Clinical Psychology and does not obfuscate the rule-systems, story-lines and moral order positions which constitute clinical work, nor the helper and patient positions. This test therefore is a kind of formalized account analysis from the position of the clinician on patient problems. Similarly,

in career counseling, for example, a group contrast procedure may also be effectively used which would have validity for discursively orientated assessment efforts. For instance, the Strong-Campbell Interest Inventory (Campbell, 1977) was based initially on comparisons of groups of successful men in various professions and occupations to men in general; scales such as "Lawyer", "Accountant", "Physician", "Psychologist", "Printer", and "Farmer" were developed accordingly. A recent revision includes both men and women's forms. The responses of the research subject's themselves were an essential aspect of the test development strategy. For the ethnic environments from which the test accounts were initially constructed at least, this test may prove useful to the clinician attempting to help someone like George, for example, with his career related difficulties. This would be particularly so if his cultural background matched the Western industrialized subject profile from where the test norms were drawn. Once again findings from these tests might be used to stimulate further discursively orientated discourse between clinician, the patient and significant members of the patient's social world. We turn now to a consideration of how discursive principles might inform attempts at improving quality of life for subjects entering into psychotherapeutic discourses.

## A DISCURSIVE APPROACH TO PSYCHOTHERAPY

Harré is mostly silent on the applied, functional aspects of psychological change since he is primarily a philosopher and theorist. His meta-theory does, however, suggest possible ways of facilitating healthful change while cursory remarks throughout his discourse also refer to conceptual points which may be developed for a clinical reading of Harré's work. In this regard, the ultimate principle about which a discursive reading of optimal health might be woven, pertains to the creative nature of character or personality construction by the individual. Harré reinforces continually that there is an important link between personality and freedom; meaning is created by the chosen self-locations of the individual within the surrounding discursive systems in which he or she may be located, over time. This progressive integrative project of self-creation is limited only by the discursive skills of the individual which may be a function of maturity, ability or novelty as well as the limitations of the significations available in the discursive systems in which they are located. In connection with these ideas, Harré and Gillett maintain that

> *"The ideal is a psychological life with the character of an artistic project and not merely a stream of experiences and responses to stimulation. Of such a life we might say that it has meaning in the same sense as a work of art has meaning. The meaning is no more summarizable in words than is a symphony or painting but it is discernible by those who are themselves well versed in discourses, their structures, and their interrelations. "* (p. 143)

This extract seems to point the investigation for a Discursive Psychology of healthful change in two important directions:

- firstly, it is clear that for the authors, personal agency is at the epicenter of psychological development and they indeed do seem to suggest that one individual be more 'agential' than another person with regards to their respective self-creation projects. It seems quite clear too that less than optimal personal development is constituted by a mere response to stimulation without the definitive act of self-creation within the limitations of located discursive contexts;
- secondly, the extract seems to indicate that individual's acting with personal agency as self-creative beings develop a sense of personal meaning which can be discerned by others who are themselves versed in the metaphors of self-creation as conceptualized by Discursive Psychology.

Both of these points suggest, therefore, that healthful change exists and, furthermore, that certain individuals are more creative about their personal projects than other individuals, and others still may also have greater insight into the discursive meaning-making processes of others. Is this a basis for building a therapeutic model? Would it be feasible to conceptualize discursive psychotherapy as the facilitation of agential responses in the patient, through social interaction with an arbiter of right action, a psychotherapist, who would mediate a new moral order with the significations of Discursive Psychology synthesized together with Clinical Psychology more broadly at the center of the psychotherapeutic process? These arguments both suggest, therefore, that indeed it seems possible to construct a Discursive Psychology position on psychotherapy as it is traditionally understood from Harré's formulations. In this regard Reber maintains that psychotherapy can be defined as follows:

> *"In the most inclusive sense, the use of absolutely any technique or procedure that has palliative or curative effects upon any mental, emotional or behavioral disorder. In this general sense the term is neutral with regard to the theory that may underlie it, the actual procedures and techniques entailed or the form and duration of the treatment."* (p.598)

Earlier on in this chapter a case for integrating psychiatric discourse with Discursive Psychology was outlined with regards to "George" for the purposes of clinical diagnosis. It was pointed out that George clearly seemed maladjusted, from both a psychiatric as well as a Discursive Psychology position. It therefore should be argued that psychotherapy might assist George in adjusting more appropriately to his life situation. We might therefore consider a possible psychotherapeutic model which is based on Harré's work in order to promote healthful change in individuals such as George which might propose new ideas as well as being sufficiently flexible to incorporate both traditional Positivist and Social Constructionist psychotherapeutic principles, strategies and techniques for the attainment of discursive psychotherapeutic goals. This is particularly pertinent in light of Harré's assertion that personal agency per se is governed by the moral order belief-systems present within

discourse; access to ideas about self-creation is contingent on the sigifications available in discourse. It would seem, therefore, that discursively orientated psychotherapy should focus on creating significations which will promote the individual's use of personal agency. It is certainly possible that traditional and alternative therapies may be usefully integrated with discursive therapy since an implicit goal of many psychotherapies is the restoration of self-control by the individual or system, no matter what its central postulates and assumptions about life problems.

These arguments are further reinforced when one focuses on the fact that all psychotherapy involves discursive rhetoric on the part of the clinician in relation to the patient's life problems; that is, all therapeutic discourse involves speech-acts of one sort or another which have been specifically formulated through focused psychotherapeutic investigation over time in order to effect illocutionary and perlocutionary shifts in the discursive interaction between both clinician and patient, and in relation to the patient's discursive interaction in life more generally. Essentially all therapeutic discourse attempts to persuade the patient towards healthful personal growth; the latent theoretical underpinnings of these deliberate speech-acts during psychotherapy are incidental to their locutionary power. Discursive psychotherapy might therefore address psychopathology as it is traditionally defined in the DSM publications by implementing the following clinical procedure vis-á-vis the referring symptoms:

**Phase I: Deconstruction**

1. Insight and clarification of implicit (unconscious) moral order belief-systems, positionings, story-lines and speech acts;
2. Deconstruction of emotionologies;
3. Interpretation of symptoms as non-optimal acts of personal agency; where the underlying generative mechanisms maintaining symptoms are explicated and articulated.

**Phase II: Reconstruction**

1. Considering alternative frames of reference; that is, alternative positions, story-lines and speech acts;
2. Reconstruction of more useful emotionologies for the promotion of self-defined goals and projects;
3. Creating social opportunities for exercising optimal personal agency;
4. Development of appropriate and useful discursive skills for moral career and personal project management;

5. Identification of a jointly negotiated long-term treatment program based upon the needs, requirements and opportunities available to the patient.

It is important, however, to note that the two phases do not describe a linear process; rather cycles of deconstruction followed by reconstruction throughout the whole therapeutic process might be facilitated by the therapist. Both Phases I and II would necessarily occur simultaneously although it would seem that on the whole reconstruction could follow only after deconstruction has been facilitated in some or other form. In this manner, increasing levels of self-consciousness, self-knowledge and personal agency might be achieved through progressive cycles of integration. It is also important to note that all skills development, reconstruction or supportive work mediated by the therapist, is entirely within the framework provided by the patient; that is, the self-defined goals, projects and concerns provided by the patient set the limits of therapeutic content. The therapist simply assists the patient in implementing their own goals through raising self-awareness and suggesting specific skills, directly or indirectly, where suitable.

The specific duration of this process might be indeterminate and could continue for as long as was required for the amelioration of symptoms. However, it is important that the therapeutic alliance does not itself replace independent acts of personal agency; patients should ideally begin to manage their moral careers and their self construction efforts through their own efforts. Psychotherapy should ideally attempt to mediate higher order self management concepts whereby the referring symptoms serve as an example of generic life problems and their resolution in terms of discursive notions. It does however seem feasible that individuals could enjoy psychotherapy at intermittent periods across their entire life trajectory: new discourses might be encountered or life situations could change, creating alternative life problems for which acts of personal agency are limited given the need for alternative skills. Moreover, changing circumstances may result in a cacophony of dissonant voices some of which may be implicit (unconscious) and would therefore need to be explicated before definitive acts of personal agency could occur in urgency. On the other hand, change itself can be overwhelming even for individuals with sophisticated agential capacities; supportive therapy might therefore be useful for well adjusted people intermittently throughout their life time as they seek ever increasing levels of optimal adjustment and psychological wellbeing. We consider now the specific methods which the psychotherapist might utilize in order to achieve these goals with the patient.

## PSYCHOTHERAPEUTIC PRINCIPLES, STRATEGIES AND TECHNIQUES

Discursive psychotherapy might draw on a wide variety of specific discursive practices originating in both ethogenic and discursive research techniques and from traditional and more radical Social

Constructionist psychotherapeutic practice more generally. Many of the former may simply be transferred intact to the clinical setting, especially for the deconstruction phases of the process. These are therefore not discussed in any detail in this chapter but the application of some of these techniques to clinical work will be demonstrated in full during the case study analysis in Part II of the thesis. The latter may be used during this phase as well as in the reconstructive phases. If, for example, George entered into psychotherapy with a discursively orientated clinician, the strategies outlined below might be adopted for each of the system levels identified earlier. We will focus primarily on the individual, dyadic and familial levels since the three case studies will involve interventions aimed at these levels. Each successive level can draw upon ideas formulated from preceding levels since Harré's formulation of the inclusiveness of individual-private dimensions with broader, collective-public structures allows for a dynamic interchange of psychological information across system levels.

**Individual Level**

**a) The Process:**

The therapist and George could discuss George's life problems in private, individual therapy sessions using ethogenic account analysis procedures as well as the semi-structured interview technique. During this process the therapist might also integrate client-centered techniques (Rogers, 1980, 1955, 1942) such as the reflection of feeling and content in order to heighten self-awareness as well as self-knowledge. In this way, George's belief-systems, his positionings within the various story-lines pertinent to his world, his psychological defenses around issues of social and personal honor and contempt, the vicious cycles of reparation and failure with regards to his positioning efforts, would become progressively clearer.

While this process would facilitate the deconstructive aspect of therapy, this could be integrated with reconstructive goals. That is, these reflective-explicatory techniques could be simultaneously synthesized with principles, strategies and techniques from various schools of psychotherapy with a more *active* focus. For example:

1) Typical systems-theoretical interventions as well as other Social Constructionist (McNamee & Gergen, 1992) interventions from narrative therapy and therapeutic deconstruction analysis might be employed in order to shift inflexible positions or simply generate further thought and problem-solving. Examples of these therapeutic notions might include the following:

> a) *Positive reframing* (Minuchin, 1974; Poster, 1978) of belief-systems which may be considered negative or unwanted by George. This would also mediate a higher order structuring principle where negative constructs might be trawled for their positive implications;

b) *Perturbing* (Bateson, 1972; Selvini, Boscolo, Cecchin & Prata, 1980, 1978) through suggesting alternative story-lines and positions on persistent problem areas or constructs and beliefs maintaining habitual perspective;

c) Assisting patients themselves at *re-authoring* dominant story-lines in their lives (Epston, White & Murray, 1992; White & Epston, 1990) by highlighting persistent themes, their socio-historical sources and the fact of their constructedness per se;

d) *Strategic techniques* such as the use of *therapeutic paradoxes or double-bind* procedures (Lidz, 1963; Haley, 1963; Erickson & Rossi, 1979) may also be used where patients appear fixed in their positions or assumptions, or are persistently uncooperative and defiant within the therapeutic relationship even though they may have initiated therapy themselves and may be desperately seeking solutions to their life problems. Strategic interventions might simply serve as a means of initiating change, fluidity and thought on the problematic concerns that the patient themselves brought to therapy and in no way would seek to manipulate the patient into positions against their will.

2) Cognitive-behavioral methods (Meichenbaum, 1977) could be used to promote thinking, self-management and other life skills in areas where George found he was unable to attain the levels of personal mastery he believed he required to implement his personal projects effectively. More specifically, the following approaches might be adopted:

a) Rational emotive behavior therapy (REBT) (Ellis, 1979, 1970, 1962) may, for example, be used to help clarify the usefulness of certain belief-systems or positions for the attainment of the patient's personal goals in terms of reality-testing, for example;

b) Beck's work with depressive patients (Beck, 1976, 1973; Beck, Rush, Shaw & Emery, 1979) might also be usefully implemented through teaching specific interpersonal communication skills or alternative self-talk or daily routines, for example.

c) Behavioral regimes with reinforcement schedules might be used to assist patients in building up personal mastery and a sense of personal agency in terms of their life situations (Bandura, 1982, 1977, 1974, 1969) as they choose to define these concepts.

3) Existential-phenomenological (Frankl, 1985; 1985b; 1969) notions of choice and personal responsibility might also be mediated in relation to these reconstructive efforts (Szasz, 1976, 1974).

4) Psychiatric medication might also be implemented where it facilitated processes leading to greater levels of personal mastery and agency. Drug treatment would be most efficiently utilized where patients were unable to enter into discursive psychotherapeutic processes. Medication would however only be utilized in the initial phases of therapy where possible, and only chronically where organic, unremitting syndromes existed. Some examples of conditions requiring psychoactive medication might include:

a) Severe mood disorders such as depression or anxiety;

b) Fluid psychosis;

c) Attention deficit and hyperactivity disorders.

d) Substance-abuse problems.

These interventions could create change which would stimulate further discourse facilitated by reflective-explicatory techniques until further self-defined problem areas emerged which required more active intervention strategies once again on the part of the patient who, most importantly, would have internalized the problem solving methodology of the discursively orientated psychotherapeutic process for themselves.

**b) The Content:**

- Psychometric Test Data:

George might, for example, complete a number of psychometric tests which met with the Discursive Psychology validity criteria outlined earlier. These might inform the content of discussion at one point during the analysis along the lines discussed previously.

- Transference Relationship:

During the facilitation process, the transference relationship (Bettelheim, 1986; Casement, 1985) with the therapist might also serve to clarify George's self-beliefs. He may, for example, construct the therapist as a nurturing parent figure, on the one hand, or an adversary, on the other, or both simultaneously. The therapist could therefore use these projections to heighten George's self-awareness by reflecting these back in typical psychoanalytically (and/or psychodynamic) orientated fashion (Sundberg et al., 1983) without reference to psychoanalytic ( Freud, 1984 (1915), 1979 (1911), 1973 (1933); Klein, 1932) or object relations (Mahler, 1976) rhetoric. The emphasis in the interpretative commentary might focus, rather, upon the relative positionings between therapist and patient given, firstly, the changing content, needs and experiences of the day-to-day vicissitudes within the patient's life and, secondly, increasing levels of self awareness and agential control as the therapeutic process evolved. Hence the transference relationship would both contain and reflect the ever changing positions and story-lines of which George was a part. Counter-transference constructions on the part of the therapist would need to be both controlled and used diagnostically and during therapeutic positioning as far as possible, as is typical of depth psychology procedure.

- Analysis of the Past:

A socio-historical, retrospective analysis into George's personal history, his earliest childhood memories, formative familial influences, schooling and adolescent experiences, initial entry into the

adult world, significant traumas from birth to the present, and so on, could also assist self-awareness for George. This should include a fairly detailed discussion of both the distant past as well as the intermediate and more recent past. The evolution of personal beliefs, positions and story-lines might be thoroughly explored in relation to the development of personal agency in a world of others and linked to beliefs and assumptions which affect his contemporary day-to-day life. The transference relationship might also be trawled for links to significant parental and other nurturing or authority figures of the past. These conceptual links might also clarify beliefs and assumptions that George held in relation to current actors in his contemporary life.

- Dream Analysis:

The content of dreams could be used to further explore George's personal world. Obviously discursive criteria must dictate the dream analysis procedure; that is, George would interpret his own dreams in terms of the story-lines and personal projects which he believed comprised his personal and social identity. The therapist could simply facilitate this exploration. Gestalt dream therapy techniques (Perls, 1976, 1971, 1969; Polster & Polster, 1973) might be especially useful here since the analysand's interpretations and associations are pivotal during the process. This is somewhat different to the psychoanalytic tendency to interpret responses in terms of theory contrary to that of the patient's world view.

- Drawings, Metaphors and Role Plays:

Other gestalt techniques (Perls, 1976, 1971,1969; Polster & Polster, 1973; James & Myer, 1987) might also be adapted for discursive psychotherapy. The following methods might be used:

i) Analysis through metaphor: for example, the patient imagines that they are a "Rosebush" through creative visualization (Allan & Crandall, 1986). Links are thereafter drawn between their self-beliefs and personal and social identities through a discursively orientated analysis. Similarly, metaphorical drawings pertaining to themselves, life contexts and concerns might be used (Oaklander, 1978; Passons, 1975).

ii) Role playing: for example, different dramatic parts vis-á-vis George's day-to-day life or from his past might be played out using the Empty Chair technique. This might express both private, unexpressed beliefs and feelings and may also assist in resolving life conflicts, for instance, contradictory subject positions or difficult decisions (Clarke & Greenberg, 1986; Conoley, C., McConnell, Conoley, J. & Kimzey, 1983; Greenberg & Webster, 1982).

- Intersubjective Discursive Space:

It is important to note that in a discursively orientated analysis, no matter which technique is utilized within the discursive facilitative process, albeit from a systemic, psychoanalytic, gestalt, existential

narrative, deconstruction or cognitive-behavioural perspective or psychiatric, for that matter, the principal *content* of all of these facilitative techniques is George's day-to-day life; that is, his experiences, thoughts, personal encounters, his wishes, frustrations and dreams - all of the things that George understands to comprise George. On the other hand, George's world is understood from the position of therapist; that is, in terms of story-lines, belief-systems, positionings and social and personal identity, within contemporary and retrospective social contexts - this marks a *discursive* interpretation of therapeutic material. Through this dialectic, therefore, it becomes possible to create an intersubjective discursive space which will emerge during the psychotherapeutic session and over the course of treatment sessions, and will comprise a blending of both the patient and therapist subject positions; both positions will thereby be altered in some form. This process itself informs a significant aspect of the content of therapeutic space. That is, the patient's specific responses to the discursive clinical metaphor is itself a crucial aspect of the therapeutic material.

It is therefore possible to conceive of one other important reconstructive facilitative technique originating in the human potential movement or humanistic psychology (Corsini, 1981, 1979) as well as in the radical Social Constructionist approaches (Cecchin, 1992); that is, *self-disclosure by the therapist.* This might be most pertinent where issues arise during therapy with which the therapist has had some involvement. This might lead to discussion, mutuality and a shared focus on problem-solving and the development of personal agency in life more generally. This can be used especially effectively where patients believe themselves to be 'abnormal' or 'inadequate' for having their respective life problem. This technique might assist in normalizing the content as well as the therapeutic situation so that patients might begin to consider alternative positions on the problem unfettered by debilitating beliefs about their social worth; negative self-appraisals such as these may simply generate redundant anxiety and interfere with optimal thinking and problem solving.

- Developmental Differences

Clinical work with individual children and adolescents could also be conducted using the outlined processes and therapeutic model. Techniques would however be adjusted according to the developmental idiosyncrasies of the young person. Therapeutic flexibility and accommodation of these patients is, however, no different to working with adults since a discursive therapeutic approach always adjusts to the patient's perspective; this is a primary concern for the therapist. All of the techniques mentioned above might therefore be used. With young children, toys (Axline, 1964; 1947; Klein, 1932) might assist the story-telling processes involved in any discursive analysis, for example, puppetry may represent character roles of significant people and positions encountered in the daily life of the child. (James & Myer, 1987). So too the use of gestalt therapy metaphors, bibliotherapy (Davis, 1986; Lawson, 1987), drama and role plays (Irwin, 1987) as well as visual art, sculpturing

and picture-making (Oaklander, 1978) might take center stage in the discursive psychotherapy session with this age group. These methods may however be adopted for any session with any age group depending on the special needs, affinities and the personal strengths and weaknesses of the patient.

This content list is by no means exhaustive; it simply seeks to outline a potential use of current psychotherapeutic signification. The creative clinician might utilize any psychotherapeutic technique from widely diverse schools of thought within the outlined parameters of Discursive Psychology's psychotherapeutic goals and its overarching meta-theory. This is of course only possible because discursive psychotherapy is in essence based upon a meta-theoretical heuristic which functions as a therapeutic 'toolkit' for coordinating therapeutic discourse albeit that discursive research methodology can also provide a distinct, novel range of 'tools'; that is, principles, strategies and techniques for therapeutic work with individuals. These will be demonstrated during the case study discussion to follow in Part II of this thesis.

**Dyadic Level**

Although there is no radical shifting of techniques and process from individually orientated work during clinical work with dyads; that is, couples in long term intimate relationships, single parent-child units, housemates, and so on, systems-theoretical (Keeney & Ross, 1992) concepts and techniques are clearly especially pertinent in dyadic cases and would enjoy center stage in these situations. Here particularly, *circular questioning* (Bateson, 1972; Selvini, Boscolo, Cecchin & Prata, 1980, 1978) and the identification of *recursive interpersonal cycles of interaction* (Ashby, 1956; Hoffman, 1983; Watzlawick & Weakland, 1977; Watzlawick, Weakland & Fisch, 1974); that is, response and counter response, are very useful constructs that can be interwoven with discursive notions of interpersonal positioning, story-lines and speech acts - typical systemic reconstruction techniques can also *easily* be incorporated within Discursive Psychology meta-theory and assist in work with dyads.

Apart from systemic approaches, all the previously discussed techniques could be implemented by simply altering the therapeutic focus from the individual to the dyadic unit. This is of course only possible since Discursive Psychology indeed conceptualizes all psychological phenomenon within a collective, socio-historical framework. Consequently the intra- and inter-personal therapeutic positions co-exist side by side. It is therefore possible to conduct dyadic clinical work together with individual sessions with the same people. Therefore marital counseling could occur by working individually with George and his wife in initial sessions, for example, and in conjoint therapy in later

sessions. Thus private and public constructs of the dynamics involved in the relationship problems might become apparent, yielding important material to be worked through over the whole therapeutic process. Conversely, the couple may choose to separate at the end of the therapeutic process and one or both parties might continue with individual counseling. In this manner, minimal information is lost during the overall therapeutic process. These practical concerns demonstrate the usefulness of a discursive meta-theory where public-private space and collective-individual dimensions are formulated into one coherent theoretical system.

**Familial (collective) Level**

All of the preceding comments in relation to psychotherapeutic treatment with individuals and dyads may be usefully applied when working with whole family systems. Where families are very large or interaction was extremely intense and rapid, it may be necessary for two or more therapists to join forces in the style of the Milanese systemic approach (Tomm, 1982). On the other hand, it is possible that one therapist could work with groups of individual family members at different times, or individually, in order to facilitate working through specific problems at various levels of the family system. For example, George might be seen initially on his own and later together with his wife, and then together with his children. Finally, the whole family may be seen together in one session. The children might also be seen individually or in dyads or other groupings. Whatever the combination, the discursive psychotherapeutic process would remain the same while adjusting to the specific demands of the therapeutic moment. Discursive family therapy would, however, provide specific discursive focus directed towards improving familial relations as indicated by the family members themselves. Contradictions, opposition or differences in these constructed goals between members would supply important content through which the family members must work together with the assistance of coordinated therapeutic action. Indeed, *discursive conflict*, whether at an individual, dyadic or familial level would provide the quintessential impetus for change in a discursive therapeutic encounter since conflict promotes discursive explicatory activity.

**Community Level**

Although this level is outside the focus of this doctoral thesis, the Discursive Psychology implications for this level must be cursorily considered in order to demonstrate the application of potential discursive interventions across multiple system levels. Discursive therapeutic formulations can easily be applied to larger group, organizational and community intervention approaches as they are typically conducted in mainstream community psychology (Bloom, 1983; Sundberg et al., 1983). A finer breakdown of these areas of concern might read as follows:

- Groups

Therapy might be conducted with groups (Yalom, 1975, 1970) from the community with specific focus such as self-help groups or crisis groups. It seems, once again, that Discursive Psychology meta-theory can assimilate these group therapeutic endeavors while also promoting these goals by adapting the therapeutic ideas mentioned above. Techniques and methodology could be adjusted for the specific group or as group dynamics changed over time.

- Organizations

The same comments can be leveled at industrial-organizational psychology or where psychologists find themselves in the position of manager in an organizational setting, such as a school or business operation (Argyris & Schon, 1978).

- Community

Eco-systemic psychology (Barker, 1965; Barker, 1978; Anderson & Carter, 1978; Bronfenbrenner, 1979, 1975) attempts to intervene into community problems by coordinating sub-systems within the community and mobilizing communities towards self-help options and smoother, self-supportive interactions. Clearly Discursive Psychology can have far reaching implications for this approach since it was initially formulated from social psychology concerns. Indeed, Marsh et al.'s (1978) intensive Empirical research into violence amongst football fans within circumscribed communities as well as amongst school children at school provides a good example of these points. Many of the early discursive principles were formulated from these studies. Therefore it seems particularly feasible to incorporate discursive ideas, those discussed above as well as more broadly at a meta-theoretical level, into community psychology intervention as it is practiced in eco-systemic approaches. Furthermore, eco-systemic therapeutic notions can also be woven into individual, dyadic as well as collective (familial) unit interventions.

- Prevention

Primary, secondary and tertiary prevention might occur through discursively orientated efforts by individuals, groups or organizations for individuals, groups or organizations (Sundberg et al.,1983). Once again more traditional efforts might be fused with discursive methodology and meta-theory which comfortably subsumes mainstream prevention approaches since they largely rely on community education, awareness building and skills development for local community empowerment (Bloom, 1983). Moreover, it seems that the discursive approach can contribute important perspective for higher order social change. That is, the crucial relevance in Discursive Psychology of fine idiosyncrasies of cultural differences, within communities and sub-systems within these, suggest that therapeutic technologies should be developed for the purpose of installing community belief-systems

which promote psychological wellbeing within communities; once a belief-system or discursive metaphor centering around the prevention of psychopathology in a community is made available, skills, structures and processes can follow. If Harré's assumptions are correct, therefore, it is essential that this higher order socio-cognitive restructuring occurs if prevention efforts are to be successful since the discursive assumptions available to a community are the limits of its freedom and empowerment. The community psychologist might therefore borrow methodologies from various schools of thought on influencing communities in order to improve the chances of the community 's uptake of the prevention significations.

## CONCLUSION

This chapter attempts to outline a broad working conceptualization of the Discursive Psychology metaphor as it has been formulated by Harré and his various colleagues for the typical concerns of mainstream Clinical Psychology. Although it is by no means the final word on the subject which yet remains to be fleshed out more fully as a clinical intervention instrument, an attempt has been made to map central concerns pertaining to mainstream clinical work with psychologically dysfunctional individuals, dyads and families to Discursive Psychology meta-theory and methodology. These theoretical illustrations and ideas will be demonstrated and articulated in detail during Part II of this thesis through three case study presentations focusing on psychotherapy at the individual, dyadic and collective (familial) levels, respectively.

# PART II

# EMPIRICAL RESEARCH

## Instructions for the use of the Transcripts And Appendix CD-ROM

The chapters in this part make use of the transcribed set of three clinical case studies, and are available on the CD-ROM enclosed with this document. The computer hardware and software operating requirements and instructions for accessing the CD-ROM are included below. The transcripts have been created using the Adobe Acrobat™ PDF format, and require the Acrobat™ Reader software. For those users who do not have this software, a copy of the Acrobat™ Reader software is enclosed.

**PC Requirements**

- Intel Based Processor 90 MHz or higher
- 32 MB RAM or higher
- 20 MB free hard drive space
- CD-ROM Drive
- Operating System: Windows 95, 98, 2000 or NT4

**Step 1: Installing the Acrobat Reader software (Perform this once only)**

A1. Place the Transcripts CD-ROM in your PC.
A2. Click on the **Start** button in the bottom-left of your screen, and click on **Run** in the pop-up menu provided.
A3. Enter **"D:\Adobe Acrobat Reader 4.05\ar405eng.exe"** in the input box provided, and click on **OK**. (Note the quotation marks on either side are required to be typed in.)
A4. Follow the rest of the setup instructions provided by the software for your specific operating system.

**Step 2: Viewing the Transcripts**

B1. To view the transcripts, click on the **Start** button in the bottom-left of your screen, and click on **Run** in the pop-up menu provided.
B2. Enter **"D:\Transcripts.pdf"** in the input box provided, and click on **OK**. (Note the quotation marks on either side are required to be typed in.)
B3. Acrobat Reader should launch and the first page of the transcript should be visible. (If an error message occurs, close all windows and redo the instructions from B1.)
B4. You may adjust the magnification by choosing **View** on the top menu, and choosing one of the **Zoom In**, **Zoom Out** or **Zoom To**... options.
B5. You may go to a specific page number by choosing **Document** on the top menu, followed by **Go To Page...** Type in the page number in the input box provided, and click on **OK**.
B6. Further information on other features of the Reader may be obtained from the Help menu, or by visiting the website **www.adobe.com/acrobat**

**NOTE: These instructions assume that D: is the drive number of your CD-ROM drive. If your drive number differs, replace D: with your drive number in steps A3 and B2 above.**

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**Chapter 6**

# The Researcher's Story

Discursive Psychology understands any research effort into the social sciences to involve an emergent (dynamic) intersubjective story-line evolving as a function of reciprocal positioning activity of the research subjects and the researcher. The researcher/s story-line, their position on the research material and their specific interaction with the research subject/s, will impact on both the research design and process as well as final outcomes and interpretations. This chapter therefore reviews the research process from the researcher's point of view while also outlining a methodological model for clinically oriented Discursive Psychology research, adapted from the range of research possibilities discussed in Chapter Four and integrated with the clinical model outlined in Chapter Five. Furthermore, this chapter is written in the first person in order to best reflect the intentions of this exercise.

## PERSPECTIVE

I chose to focus on three case studies involving clinical psychotherapeutic work with individuals, couples and family systems as units of intervention in the therapeutic context of the practitioner's consulting room. In this way I hoped to illustrate how discursively orientated treatment of the typical, everyday psychotherapeutic case scenarios I am confronted with in private practice can be effected. More specifically I created the following research design in order to illustrate my contentions discussed in Chapter One:

- Case 1: the ***collective*** unit, involved family systems psychotherapy (concurrent with individual play therapy) in order to assist a symptomatic young person (nine years old) to improved adjustment through the treatment of his family constellation (mother, father, teenage sister) as a whole;
- Case 2: the ***dyadic*** unit, involved couples/pairs psychotherapy which focused on treating a heterosexual couple in an intimate relationship experiencing psychological difficulties within interpersonal discord;
- Case 3: the ***individual*** unit, involved clinical work with an adult person (diagnosed psychiatric patient) in individual psychotherapy experiencing life adjustment difficulties.

At least one of the actors in each case study met DSM-IV classification criteria for one or more psychological disorders. Although I deliberately chose the individual unit research subject because of his specific psychiatric labeling, there was no deliberate pattern to any other choices of psychiatric

condition since the goal of my doctoral thesis is to show how *any* psychological disorder may be treated using Discursive Psychology principles. By adopting this triadic research design, I could also consider, therefore, the psychotherapeutic implications of discursive clinical work with people across ontogenetic developmental boundaries, across gender identifications and in relation to the severity of clinical symptomology, as defined by traditional Clinical Psychology metaphors which informed my training as a clinician; that is, from childhood adjustment disorders in the collective unit to the severe psychiatric disorder presented in the individual unit. The cases were therefore chosen primarily at random; I simply selected the collective and dyadic unit cases from the regular referrals to my private practice when I was ready to begin the Empirical research. The individual unit research subject was a special case inasmuch as I deliberately searched for a candidate who had been previously diagnosed 'borderline personality disorder' by the psychiatric community. This was done in order to breathe life into the theoretical example of "George" which had informed my initial tentative clinical formulation of discursive principles based on Harré's discussion and illustration (see Chapter 5) - a real life example seemed fitting, therefore. However, a few superordinate principles did indeed inform my final selection and need to be explicated; that is

- subjects were in a financial position to follow psychotherapy through and not drop out due to funding shortages. In the case of the individual unit, however, the subject was seriously impecunious and I therefore agreed to conduct the therapeutic work free of charge and indeed even paid for any transportation costs to and from the clinic.
- all the research subjects were people who reflected my socio-cultural origins as a white South African. I had been encouraged to select this type of candidate by my research supervisor and his colleagues during a critical review of the proposed research effort since I would be able to better relate to and understand subjects' idiosyncratic discursive practices. Indeed my psychotherapy practice typically consists of patients from a wide range of different cultural groupings and I enjoy this multicultural diversity! However, for the purposes of this doctoral project I chose to restrict my scope in order to fulfill requirements of scientific rigor.
- candidates represented the two primary language communities among South Africa white people; that is, English and Afrikaans, although there are many other language groups among white people given South Africa's colonial past. Although I am primarily English speaking, I have been exposed to the Afrikaans (Dutch-settler origins) language and community since I can remember. It was an obligatory second language inculcated at school from kindergarten and I completed a master's degree at an Afrikaans university during my adulthood which allowed me to register as a clinician. Furthermore, the Afrikaans speaking community provided the most accessible alternative language community for me while growing up since some of my relatives married into this community. For these reasons I chose candidates who were representative of Afrikaans and/or English speaking South Africans.

- subjects were also selected on the basis of their discursive skills; that is, on the whole, I selected candidates who were articulate and capable in their speech-acts. Any serious speech impairment or withdrawn, 'silent-types' were avoided in order to best position myself in terms of my research goals. The youngster participating in the collective unit analysis was also selected since his verbal intelligence (high average)was slightly in advance of his chronological age. Candidates with severe learning disabilities or debilitating organic conditions were also avoided for this first study into discursive clinical applications although this would be an interesting concern for later investigations. Unfortunately, the individual unit candidate was often under the influence of heavy psychiatric medication which affected the efficacy of his discursive articulation, memory and concentration. This had not been apparent during the candidate's screening and only emerged later on in the research process. This was immensely frustrating at times and made transcription of his sessions an arduous and heroic feat! In retrospect, I would have chosen a candidate who was less *intrinsically* affected by psychoactive substances for this first investigation. Nevertheless, research with this subject was productive and I believe that my research aims were sufficiently met despite the chemical interference.

Initially I endeavored to formulate a research design which would integrate *all* of the theoretical points made in Part One. This ambitious project was however not fully realized during the case studies; the initial research design became progressively more idiosyncratic as the research process evolved - my original intentions had to be re-formulated in order to accommodate the emergent story-lines and needs of the psychotherapeutic moment. The original research design was somewhat rigid in its structure and included a host of adapted traditional, ethogenic and discursive research instruments and techniques much of which had to be reformulated. I will now, therefore, consider firstly, the overall research strategy before discussing each case study unit in some detail in terms of initial research design intentions and rationale and the process of re-structuring the final, emergent research design. No doubt I will entertain yet further alternative re-structuring possibilities for this project given critical feedback and the passage of time.

## GENERAL RESEARCH STRATEGY

Each case study was sub-divided into three, distinct *analytic* (formal, abstracted, ideal) phases for planning, orientation and evaluation of the actual, emergent research *process* and included the following:

1. Deconstruction: various ethogenic, discursive and more traditional psychotherapeutic tools and instruments were used to 'unpack' prevailing story-lines, speech-acts and positions. This phase

was further sub-divided into three sub-phases: ethnographic observation, account analysis and action analysis.

2. Reconstruction: various psychotherapeutic intervention procedures from both traditional and more radical Social Constructionist schools of psychology, as well as some completely new ideas modeled off discursively orientated principles, informed therapeutic reconstruction efforts.
3. Evaluation: using a range of different techniques and methods, the outcome of psychotherapeutic interventions was evaluated through the self-reports of the patients' themselves as well as the psychotherapist/s concerned.

Although the first phase was more dominant during the beginning of the research process and the final phase ascendant towards its conclusion, these three phases did not occur consecutively but rather informed ongoing cycles of deconstruction, reconstruction and evaluation. Process notes were made after each session and activity and the discursive material from each session was videotaped for transcription purposes. Moreover, all cancelled sessions, discussions and decisions made outside of the consulting room were recorded in the process notes as well. Both the videotapes and process notes were reviewed from time to time as each intervention procedure was planned during the course of treatment.

The research timeframe and procedure attempted to reflect psychotherapeutic intervention as it is traditionally practiced; that is, 50-60 minute sessions, once or twice a week, depending on need. While these practices may well be different for other countries, these are typical timeframes adhered to by South African psychotherapists and certainly informed my training.

In order to reflect the process of the development of the psychotherapeutic story-line in each case study, a full transcription of each session and discursive exercise has been included in a separate volume (Vol. II: see introductory discussion at the beginning of Part II). The only exclusions to this are the last two individual unit sessions, one of which was fully transcribed except for minor editing, and one from the family unit given last minute re-scheduling and the absence of a video camera. These former sessions were excluded as part of an effort to bring about closure on an otherwise endless activity although the individual unit came to an end quite suddenly (unpredictably) thereafter - any further transcription seemed redundant for the task at hand since I had more than enough illustrative material! Videotaped sessions were transcribed *verbatim*, for the most part, and any Afrikaans commentary was transcribed as spoken with full English translations. As discussed at the beginning of Part II, a cross-referencing system between the two volumes will hopefully assist the reader to both contextualize the illustrated points and provide an immediate sense of the psychotherapeutic process as it is conducted from a Discursive Psychology position; the all important

*time* and *process* dimensions which are often missing from social psychology research projects, as well as the verbatim positions of the research subjects and the researcher as they perceive them, will be made fully transparent for the critical reader. It was well worth the hard work since scientific rigor has not been compromised and the research process and presentation are congruent with the overarching meta-theory. The transcripts were completed by me together with my personal assistant at my private practice. In this way confidentiality could be maintained since she is bound under oath to safeguard patient information.

Furthermore, permission was obtained during the initial intake interviews (ethnographic phase) from each of the candidates (the parents in the collective unit) before commencing the research project. I informed them that the material would be used for professional purposes and supervision - this accounted for the presence of the camera in the consulting room. Case material was also discussed with by my clinical supervisor (Senior Clinical Psychologist) who assisted me in the case management of the various therapeutic units. I was cautioned by him to ensure that the individual unit candidate signed a detailed document (see Appendix - Section 3.1 p 1014) explaining the limits and expectations of the research activity since his official status as a disabled psychiatric patient positioned him in a complex network of miscellaneous treatments by various practitioners and therapeutic systems. Together with my supervisor, I therefore formulated a contract outlining the research process and its relation to traditional psychotherapy which the patient signed in the first session.

Confidentiality was guaranteed to all research subjects and a *concerted* effort has been made to edit out any identifying personal information from the transcripts or case discussion while still preserving actual story-lines and discursive authenticity. Please refer to the discussion by Patrick Casement (1985), a mainstream psychoanalyst, on confidentiality issues in psychotherapeutic research in order to identify the ethical context of the choices I have made in this regard. At points I have obscured the specific content (e.g., using pseudonyms) rather than simply editing out certain compromising aspects. Indeed, I have made every attempt to represent the discursive content as it was presented to me and have edited or obscured only very minor episodes or speech-acts. This also pertains to *my* contribution to the therapeutic discourse. I have only adjusted any personal speech-acts for the sake of clarity or confidentiality. A further confidentiality proviso will ensure that no other person will be allowed access to the original videotapes - the transcripts should adequately represent any discursive reality for scientific purposes.

It is important to note that transcriptions are written in *plain English* and no attempt was made to use the Jeffersonian or any other transcription coding system. The reason for this is that these systems are

often totally incomprehensible to anyone other than a few patient initiates. Furthermore, it is argued that if this thesis is to have any practical resonance in the contemporary world of psychotherapy, the more accessible the language medium then the more likely its uptake, its *conventionalization* (see Chapter 3). Indeed, if one considers textbooks or written commentary on therapeutic psychology, most case studies transcribe patient discourse using the regular, standard written English conventions typical of dialogue in novels, newspapers, magazine interviews and the like. This is also true of ethogenic studies, for instance, into football hooliganism. What is lost in scientific rigor fosters a vastly more *accessible* enterprise which is, firstly, the ultimate goal of this doctoral project and, secondly, is indeed consistent with Harré's ideas on the operation of skillful discursive agency within the confines of social discourse; that is, successful entry of new metaphors into social discourse is at least contingent upon their relative compatibility with the prevailing discursive conventions. Although these discursive practices may well change, the outlined position appears, however, most useful for this doctoral research endeavor at the present time. Finally, I have attempted to present the transcripts in dispassionate manner, as an objective report beyond my interpretation. I have therefore referred to myself as "the therapist" in the transcripts and have attempted to keep any of my own descriptive comments to an absolute minimum. I do however fully acknowledge that the transcripts are not 'objective'! During this whole process I indeed became painfully aware of the subtle complexity involved in any representation of everyday discursive practice in action.

Each case study illustrates different methods although each is unified with the other under the methodological umbrella of Discursive Psychology more generally and the three phase process outlined above more specifically. In this way it has been possible to illustrate the possible workability of the research methodology and methods considered in Chapter 4 as they relate directly to the concerns of Chapter 5; that is, as discursive research applies to discursive psychotherapy in practice. These methods should however be understood as contingent and in no way should each respective research method be understood as restricted to work with individuals, dyads or larger family groups as they are presented in this thesis; each method may be applied to every other unit or case, if so required. I have simply punctuated the therapeutic approaches in this thesis in a manner which suits the needs of my project.

Importantly, each case study has a chapter devoted to a full explication of the psychotherapeutic techniques and processes utilized, their therapeutic relevance and the meta-theoretical points being illustrated as these pertain to the discursive clinical psychology project as a whole, and a rationale as to their specific use in each of these unique clinical cases. This chapter therefore focuses primarily on research procedure and concerns although the research and psychotherapeutic aspects are linked together in a complex synergy. Consequently there are small overlaps in discussion between this

chapter and the later psychotherapeutically focused chapters although I have made every attempt to refrain from any redundant repetition while still maintaining a readable coherency for the reader.

## THE RESEARCH PROCESS

More specifically, the following research procedures and methods were adopted for each respective case study:

### I. Collective Unit

### 1) DECONSTRUCTION

**Ethnographic Observation_**

While informal account and action analysis clearly took place during this phase, primarily these early probings were informed by my ad hoc impressionistic observations of the members of the family unit and included the Clinical Psychology position on the presented story-lines. This initial position was therefore informed from the 'outside' rather than from the *family's* point of view; that is, from the 'inside'. From an ethogenic methodological position, an ethnographic observation process was a necessary forerunner to any further deconstruction from the 'inside'. The ethnographic observation process ran as follows, therefore:

**a) Intake Session:**

The parents were first seen in an intake session in order to contextualize their child's problems as they understood them and provided a brief family and developmental history. This interview was conducted alone with the parents without any other family member being present. From an ethnographic perspective, *my* interpretations of their discourse were indeed central at this time although informal account and action analysis occurred throughout the intake interviewing procedure. For the most part, therefore, this was a standard 'first session' typically used in traditional clinical child psychology. That is, a clinical questionnaire that I had compiled from an assorted number of similar intake questionnaires from different clinical sources which marked the process of my training, was completed together with the parents. While their responses were written down, the clinical methodology constructed the direction of their conversation and, in this sense, the clinical context and procedure and my position as psychotherapist constructed the situation through the discourses it facilitated, in a similar way to ethnographic observation of exotic tribes, perhaps - that is, from the 'outside'. At this stage I had not even entertained the possibility of including this case as part of this research project since both parents seemed very uncomfortable with the whole process.

While the mother had initially requested the services offered by myself and my team of associates who specialized in child and family related problems and seemed keen to address her son's difficulties, the father was hesitant and unsure as to the necessity for psychotherapeutic intervention. Indeed, on first impressions it seemed quite possible that the parents would not follow through on the therapeutic process at all! However, there was a positive discursive indicator in that the father had taken time off work in the middle of the afternoon to attend this first session although negative indicators abounded especially when I asked questions pertaining to his family of origin. Moreover, the mother at one point said quite explicitly that she had spent some time trying to convince her husband to attend the interview since he didn't really believe in psychotherapy, generally speaking. I had tried to remain 'neutral' in my response to his disclaimer (as far as I was able), and suggested that we administer a psychometric assessment in order to better understand their son's difficulties and then decide on a course of action thereafter, to which they both agreed.

**b) Diagnostic Psychometric Assessment:**

My psychotherapeutic training dictated a full psychometric assessment where young people were referred for treatment. The procedure followed in this case study therefore follows this model which I understand to be fairly standard practice in clinical child psychology in traditional approaches. The clinical assessment was based *exclusively* on traditional clinical assessment techniques with young people; that is, using traditional psychometric tests which included IQ, perceptual, scholastic and emotional batteries, all of which were endorsed by medical aid funding. The choice of tests was therefore informed by contemporary story-lines in mainstream psychotherapy with children and practical considerations such as funding endorsement.

Although the psychometric testing division at the clinic is overseen by me, the test administration was conducted by a psychometrist, this is again standard practice. In this case, however, the psychometrist was a fully trained psychotherapist who had just completed her training and had graduated with distinction. On the basis of the test results and the initial intake information complied by me, the *psychometrist* formulated a clinical diagnostic report (see Appendix - Section 1.2 p 995). Although I checked the report by reading through it, essentially its contents are the work of an independent clinician employing contemporary mainstream clinical child psychology story-lines. This is yet another means of generating multiple positions on the case material since each clinician inevitably punctuated the test results from their own position, as both clinician (social identity) and in terms of their self-positioning (personal identity) in relation to the story-lines involved in the patient's referral. This procedure therefore is isomorphic with the ethogenic research methodology emphasis on the need to generate multiple positions when researching psychological phenomena. In this case,

researchers from alternative cultural or disciplinary backgrounds were replaced with the outlined clinical procedures. This procedure demonstrated the interface of discursive clinical methodology with contemporary mainstream clinical constructs, therefore.

Continuing to conform to traditional procedure, a feedback session on the test findings was scheduled for both parents approximately two weeks after the test administration.

**c) Feedback Sessions**

Only the mother attended the first feedback session since the father was unable to join us due to work commitments. She was given a copy of the diagnostic report at the beginning of the session and all the test results were explained to her in some detail. This did not take very long since the results pointed almost exclusively to emotionally related difficulties and therefore the other areas of functioning needed little further elaboration. After I had gone through the emotional difficulties outlined in the report, the mother of her own accord began to express her view on her son's difficulties; in short, it was her husband's fault! Since he was unable to attend this session, she scheduled another appointment for a week later, in the evening this time in order to ensure her husband's presence and they both arrived as scheduled.

The father had read the report during the ensuing week and had been most impressed by its contents since he felt that it was an accurate reflection of the situation. For this reason he had consented to continuing with the proposed treatment possibilities which had been suggested in the concluding remarks of the report. After much discussion and clarification of the therapeutic rationale and procedure for the proposed treatment, the parents decided that weekly individual play therapy sessions in the afternoon after school for their son, and weekly family therapy sessions in the evening after work would be most beneficial. I made it clear at this stage that play therapy tended to be a longer term treatment option with no specific duration while family therapy would comprise eight sessions. The latter might therefore be understood as a kind of training course in order to assist their *son's* adjustment. They believed that by including their teenage daughter in the process, it might assist their son's confidence and cooperation since she was well adjusted and didn't experience his psychological difficulties and she would therefore assist in his 'training'.

At this stage I decided to include the family as a research case study for this project. I discussed this with them and framed the enterprise as furthering *my* professional expertise; that is, as *action research*. I outlined the need for videotaping the family sessions and clarified the role of my clinical supervisor - this would ensure their very best treatment. I emphasized that any confidentiality would remain uncompromised. Thereafter appointments were scheduled.

After this initial data collection and contracting agreement, I decided to focus on all *collectively* orientated therapeutic activity. The dyadic (parental subsystem) and individual (child) level intervention ran concurrently with family therapy, in couples therapy with the spousal subsystem and in ongoing play therapy with the youngster. Although this was not my primary focus, I did however wish to illustrate through this particular case study how the discursively orientated clinician might work at multiple system levels at the *same time* in order to achieve therapeutic goals. I have therefore included two transcribed sessions illustrating the individual play therapy (individual level) as well as parent guidance/ couples therapy (dyadic level), respectively, as well as seven of the eight completed family therapy sessions (collective level).

Furthermore, the play therapy session provides an important illustration as to how *discursively* orientated individual therapy might occur with a young person (see Session 1, p 3). The play therapy began a week prior to the family sessions and ended some weeks after its completion. The discursive material collected during the play therapy sessions helped inform the strategies and content of family therapy, and vice versa, since the material could be understood as an informal account and action analysis although the focus of therapeutic attention during play therapy was largely on reconstruction. For *research* purposes, I intended to look closely at account and action analyses as these were effected at a *collective*, group level in this particular case study.

**Account Analysis**

All account analysis procedures were conducted with the family system as a whole, as a collective unit, and included the following:

**a) Circular Questioning re Bene-Anthony Family Relations Test:**

During the first family therapy session (see Session 2, p 22 ), the members were asked to discuss the Identified Patient's (IP) responses to the Bene-Anthony Family Relations test (Bene & Anthony, 1978) . This is a socially orientated but psychoanalytically influenced, mainstream and much utilized test in clinical child psychology which outlines the respondent's view of the family system along important relationship dimensions such as negative and positive outgoing and incoming relationship messages vis-á-vis the IP and the other family members. The test had been administered and scored during the psychometric assessment with the IP at the individual level. During this account analysis phase, however, this traditional assessment instrument was used in quite a different manner, thereby illustrating the workable compatibility of mainstream clinical work with children with the principles of discursive clinical psychology interventions. Moreover, the permeability between individual-private and the social-collective dimensions could also be illustrated in this manner.

More specifically, the following methods were employed in this first phase of the account analysis with the family; that is, by integrating the use of laddered 'Why?' questions typical of account analysis procedures from ethogenic research methodology with circular questioning techniques used in Milanese systemic family therapies, I attempted to facilitate a family account of the IP's original responses to the Bene-Anthony Family Relations Test. These were presented in graphic and written summary form to all of the family members in a separate handout (see Appendix 1.4 p 1001). The discussion began to explicate the family's beliefs and assumptions about the relationship dynamics within the family as well as *their* understanding of the collective contributions of the family system to the maintenance of the IP's symptomatic behavior

**b) Repertory-grid Work**

During the second family therapy session (see Session 3, p 41), repertory-grid (rep-grid) questionnaires were completed by all of the family members individually. The topics used were compiled on the basis of all the ethnographic observation data collected so far as well as on the information gathered during the first family therapy session. I based the rep-grids used in all three case studies on ethogenic research methodology and adapted them for clinical activity. No quantitative measures were utilized in the rep-grid analysis and the thematic analysis was provided by myself rather than directly by the research subject to begin with although any constructs were generated by the subjects themselves thereafter. The rep-grid questionnaires comprised single A4 size pages with different topic headings, all of which had the following generic format:

- **Topic: Handling Conflict**

(The family rep-grid topics included: conflict; anger; trust; achievement; the past; rejection; caring and support; communicating; doing things together; friendships; being assertive)

**Section A:** Name two people that you know who **handle** (conflict; anger etc…) with other people *correctly.*

1................................ 2................................

What is *common* about the way they handle (conflict; anger etc.)?

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**Section B:** Name two people that you know who handle (conflict; anger etc.) with other people *incorrectly.*

1.................................          2.................................

What is *common* about the way they handle (conflict; anger etc.)?

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**Section C:** Compare your responses in A and B above with each other. Why is A more correct than B?

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The following written instructions were attached to each questionnaire:

1. Please use a pen only
2. Complete all sections required.
3. Answer the questions as quickly as you can.
4. Do not spend too much time thinking.
5. Put down the first thought that comes to you.
6. You may refer to any person that you know or have known in the past or who you know presently.
7. You do not have to know any of the people you mention well or be absolutely sure that what you are saying is correct about them.
8. It is important that you are absolutely honest and speak your mind.
9. Your opinion is all that matters in this exercise.
10. Please do not discuss your responses or ideas with anyone else.

This rep-grid format allowed me to hone in on specific topic areas that I required more information about given the referring clinical problems and the envisaged psychotherapeutic intervention. In this manner the volume of information generated by a more loosely constructed rep-grid format could be kept to a minimum since indeed this may have been overwhelming for all parties involved, including myself. It was important that I kept all administration processes both simple and streamlined given the time constraints and the specific nature of the information that I wished to gather.

Furthermore, the format's simplicity allowed me to work with the information gathered in the rep-grids with the research subjects themselves during the therapeutic process. For example, during the last family therapy session I asked all members to re-read their original responses and discussed any changes that they might wish to make (see Session 8, p 160). This approach therefore liberated the rep-grid questionnaire from a purely diagnostic instrument by integrating the method for psychotherapeutic reconstruction.

During the administration, the youngster asked if he could quote a character from a children's television program. I agreed to this since I both knew the character (Homer, Bart Simpson's father) and felt indeed that discursive meta-theory could account for this permutation to rep-grid methodology which typically requires using real, everyday people in the respondent's world (see p 47). Clearly I was still able to discover super-ordinate principles (story-lines) regulating the boy's discursive assumptions around the indexed topic since the respondent thought of the character and linked this conceptually to real people in his world.

Although 'Why?' questions are not usually part of the rep-grid formula and pertain rather to ethogenic account analysis procedure, a 'Why?' question directed at their moral justification of their responses to sections A) and B) was included in Section C); this identified higher order moral principles surrounding each construct. On the whole, however, my rep-grid procedure maintained all the intrinsic principles pertaining to the use of rep-grids (see Chapter 4).

No computer assisted rep-grid analysis was attempted although these have been used successfully in social psychology research. This is certainly an interesting and important direction for future research since both rep-grid administration and analysis may be more effectively managed with computer assistance, especially in clinical practice where timeframes are always important.

The rep-grids also provided important clues about each member's position in the family and the larger eco-system through an analysis of their written discursive skills and their approach to completing the form (the mother, for example, was constantly concerned about spelling and grammatical errors). The exercise also attempted to capture each family member's independent, personal constructs at the private-individual level and each member was therefore required to complete the questionnaire alone and not discuss their answers with each other. They were also asked to complete the whole rep-grid using a pen so that their first thoughts and any subsequent changes could be recorded. If a pencil and rubber had been used the process of rendering written discourse would not have been as transparent to me and I needed to acquire as much material as possible in the

shortest amount of time about the discursive practices of the family, both together and as separate family members at a individual-private level. I therefore assisted the youngster to complete his questionnaire by asking him the questions verbally and then writing down his answers. This saved time given the developmental status of the other family members and avoided his comparative limitations and lack of exposure to similar tasks. These aspects might all have been very threatening for a nine year old and might have caused unnecessary distress, invalidating the information gathered - discursive presentation may have become the overriding concern for the youngster.

The questionnaires were completed together in the same consulting room by the mother, father and sister. I sat in a completely separate room and completed the questionnaire with the child during the 50-60 minute session. We all finished at more or less the same time, towards the closing minutes of the session. This procedure worked well and none of the family members complained or seemed unduly distressed. Please see Session 3 (p 41) for a full transcription of the family members' rep-grid responses including any changes and errors that they might have made.

**c) Moral Dilemma Exercise**

In the third family therapy session (see Session 4, p 58) the family debated a moral dilemma story (see Appendix 1.5 p 997) which I constructed about a situation that included important discursive themes, constructs and problems within the family which had been revealed through the preceding research processes. The story necessarily referred *indirectly* to the family's issues since in this manner any emotionally threatening material could be discussed but at a 'distance', as it were, and although references were made to their actual family life during the debating process, I responded quite neutrally, neither encouraging nor discouraging the direction of the discourse. On the whole, however, I attempted to facilitate deconstruction analysis by escalating conflicted interaction (also see 'escalating stress' in Chapter 7) between the family members, a meta-level ethogenic technique for the explication of implicit rule-systems and assumptions. The procedure also involved substantial role playing and I used various methods to induce the players into their various roles (also see Chapter 7). Through this process further story-lines, speech acts and positionings pertaining to their problems as a family emerged.

Most importantly, however, the moral dilemma exercise included critical re-constructive components and not only revealed further implicit, immanent family dynamics and assumptions. The method facilitated the integration of the two conflicting story-lines comprising the moral dilemma and the formulation of a new, more effective formula for dealing with interpersonal conflict for the family (see Chapter 7).

**d) Informal Account Analysis**

Throughout the therapeutic process it was possible to access the family's belief systems and discursive assumptions by simply using laddered 'Why?' questions in various forms; that is, by requesting that family members reflect on their discursive practices and justify why indeed they aligned themselves in the particular way they chose - this occurred during all phases of the research (eg, see p 4, 30).

Importantly, I found it is possible to use any number of speech acts to effect a 'Why?' question; for example, substituting 'why' with words or phrases such as 'because...?', 'inasmuch as ...?', 'in order to...?' etc.. Furthermore, I have discovered through my detailed transcription of the sessions that the 'reflective listening' techniques from client-centered counseling as well as the 'reflective statements' made by psychoanalysts during traditional psychoanalysis are actually a form of questioning that implies a justification. That is, if one of two or more interlocutors uses a 'feeling reflection' such as, 'You feel sad' or a 'reflective statement' such as 'He reminds you of your mother', then the person (or group) being addressed needs to refute, accept or ignore (e.g. change the subject) that particular discursive positioning as an interlocutor. The therapist might for example rather ask, 'Do you feel sad about that?' or 'Does he remind you of your mother?' which would demand a justification. It seems therefore that these speech acts are in fact disguised 'Why?' questions demanding some kind of moral justification response. I have used these basic techniques throughout the therapeutic process, as informed by my training as a clinician.

**Action Analysis**

**a) Co-operative Inquiry**

The fifth session (see Session 6, p 109) (see below for the contents of the fourth family session) was devoted to a viewing of a video recording of the first family therapy session (Bene-Anthony Family Relations Test discussion) by the family as a group. They were asked to comment on the family's *interactions* during this session. Together with me, a co-operative inquiry (co-inquiry) discussion focusing on 'How?' the family interacted was conducted; that is, speech-acts and positioning sequences informing family communication (eg, see p 110).

This co-inquiry attempted to map their mutual interaction in the clinical context to what actually occurs in the home environment and, furthermore, considered how these mechanisms may have contributed to the maintenance of the child's symptomatic behavior. This method therefore made an action analysis possible from the point of view of the subjects' themselves and also allowed for increasing levels of self-awareness about each family member's individual position within the family, and their interaction as a collective unit. The method worked well from both a researcher's position

and as a therapeutic technique since both account and action analyses were possible while re-construction of more useful interpersonal discursive practices was also apparent. Please refer to the action analysis discussion in this chapter pertaining to the dyadic unit for further elaboration of these ideas.

**b) Informal Action Analysis**

Informal 'How?' questions were asked throughout the therapeutic process by me and also occurred spontaneously throughout our discussions. I therefore substituted 'how' with phrases such as 'And then what did you do?' (eg, see p 36) during circular questioning in order to deliberately move the family discussion into an informal action analysis or I would bring process issues into the foreground when action analysis occurred spontaneously (eg, see p 113). Furthermore, I would deliberately reflect back to the family members the process of their interaction as they assumed and rejected various positions in relation to each other and the therapeutic process (eg, see p 37).

**2) RECONSTRUCTION**

**a) Milanese Systemic Family Therapy**

The fourth family therapy session (see Session 5, p 83) would have ideally followed the fifth session outlined directly above according to the original intervention plan; that is, reconstruction work should have followed the action analysis of the deconstruction phase. However the collective therapeutic focus of this session required the services of two other co-therapists which necessitated advanced organization and coordination given their very busy therapeutic schedules and time commitments. Therefore I had to estimate the respective timing of the activities for the various sessions. Accurate predication was however difficult since some sessions were cancelled and rescheduled by the family and I therefore went ahead with the sessions as they emerged in the process; little therapeutic or research positioning was lost through this permutation.

The approach adopted was similar to that used in the Milanese family systems interventions (see Chapter 5) since the therapeutic team consisted of three psychotherapists who worked together in this particular session to facilitate therapeutic change within the family system. I was one of the therapists in the consultation room and was joined by a female co-therapist who also interfaced directly with the family in the room. A television monitor was rigged up in another room and connected to the video camera in the consultation room which simultaneously recorded the session. The consulting room proceedings were viewed by a third, male co-therapist via the television monitor although he never interfaced directly with the family. Should he wish to make a comment on the therapeutic activity, he would knock on the consulting room door and the female co-therapist would

leave the consulting room and join him at the television monitor where they could both discuss therapeutic matters in private, away from the family. She would then return to the consultation room where the family and I were still engaged in therapeutic discourse and attempt to integrate their observations and decisions into the therapeutic positioning activity (eg, see p 105-106).

In this way multiple positions on family interaction and story-lines were possible and provided flexible positioning on the subject matter beyond my limited perspective. Moreover, the complexity of family therapy can obscure the content of story-lines, speech- acts and positioning and indeed the single family therapist can benefit from the support of co-therapists! This diversity was further sharpened since I deliberately chose a female co-therapist, on the one hand, while the other male co-therapist was a visitor to Cape Town and had lived in a neighboring African country for most of his life. Therefore diverse cultural and gender positions on the family's discursive practices became possible and added to the discursive repertoire available for initiating optimal change within the family's discursive practices while mirroring ethogenic research emphasis on cultural diversity and observer multiplicity.

The team members met for a preparation meeting where I presented the case to them via discussion and video footage of the previous family therapy sessions. After untangling various themes and positions within the family system, we formulated a therapeutic strategy which we hoped would be most suitable for the attainment of our mutually agreed upon therapeutic goals and intentions. We rehearsed this briefly although we were all aware that we would need to work in the process which was largely unpredictable. The planning meeting lasted just over ninety minutes. Although this meeting was recorded, I felt that a full transcription was unnecessary since the team processes are reflected best in the transcription of the actual session.

The process was useful albeit that the therapeutic team had never worked together with this method before although that each of us had been exposed to the approach during our training as clinicians. As mentioned, there were practical difficulties in coordinating the respective therapists' time and resources; indeed, we had included a fourth, female member on the team to join the male co-therapist at the television monitor outside of the consulting room but she confused her dates and never arrived for the session! Fortunately it was possible to go ahead without her although if any other team members were absent, it would have seriously compromised this reconstruction procedure. These difficulties do, however, point towards the potential impracticality of coordinating the services of teams of practitioners in discursive clinical psychology. This point also becomes pertinent in private practice when consultation fee costs need to be considered. I dealt with this point by taking my two

co-therapists out for supper after the session as a way of both thanking them for their once-off assistance and providing a pleasant forum for debriefing.

**b) Mediating Specific Discursive Skills for Interpersonal Conflict Resolution**

An important component of the reconstruction phase was the active mediation of specific discursive skills to the family members. These concentrated specifically on conflict resolution skills since dealing with interpersonal conflict was a primary concern in this particular family. The details of these skills will be discussed during Chapter 7.

**c) Eclectic Methodology**

Many the techniques typical of traditional systemic family therapy as well as some other intervention techniques from other schools of thought were integrated together to assist the family reconstruct their interpersonal world according to their self-reported goals. These various techniques were chosen and utilized given the needs of the therapeutic positioning and are discussed in Chapter 7.

**3) EVALUATION**

**a) Repeating the Original Repertory-Grid Questionnaire:**

During the sixth and final family therapy session (see Session 8, p 180) it was necessary to evaluate the therapeutic procedure so far and therefore the original rep-grid was re-administered and completed by all family members at a private-individual level. At no point during the research procedure did any family member have access to the private ideas of any other family member, only I had access to these private ideas. Therefore each member evaluated only their own rep-grid constructs and shared any changes in their ideas at the public-collective level at their discretion.

This procedure attempted to provide a qualitative indication of therapeutic change as each family member perceived it. Although only comparatively few constructs had changed in any marked way, a few key constructs identified as problematic through the research-therapeutic process seemed to have shifted somewhat (e.g., see p 165-166). By comparing the original rep-grid responses with these latest responses, it was possible to extract salient themes and issues that had either been resolved or remained unresolved, had changed or seemed unclear or contentious. An unstructured family interview method combined with circular questioning techniques was therefore applied to the whole family unit and in this final family therapy session, the family considered important questions pertaining to the original referring problems, the therapeutic process as well as their perception of future family considerations.

**b) Parent Guidance Session**

A final parent guidance session (see Session 9, p180) with the parental (and spousal) subsystem alone also attempted to evaluate therapeutic progress. This session relied on both specific discursive research techniques (unstructured interview with grounded theory) and standard parent guidance evaluation using techniques applicable for couples/ pairs (dyadic level) psychotherapy (also see Chapter 8). I used their son's art productions from the individual play therapy sessions (see Appendix 1.8 p 1011) to clarify my therapeutic evaluation and ideas for continued treatment so conjoining the individual-private focus with the collective-public level.

During this session the parents agreed to continue with play therapy for a while longer although the mother felt that her son was much improved and no longer required treatment. The boy attended a further three sessions and then the family decided to terminate all treatment since all the original referring problems were considerably improved - he was 'a changed child'. This message was conveyed to me telephonically by the father. I have never heard from them again.

**II. Dyadic Unit**

**1) DECONSTRUCTION**

**Ethnographic Observation**

**a) First Contact**

Initially the female partner made contact with my personal assistant at my private practice on the recommendation of an acquaintance. She had requested that I phone her before making an appointment since she believed that her situation was complex and therefore thought that I may benefit from some orientation. I simply listened without saying much and then scheduled an appointment for her and her male partner to attend the first intake session together. This first telephone call already provided an ethnographic observation position on the couple's issues albeit it brief and limited (see p 202-203).

**b) Initial Intake Sessions**

As with the initial intake sessions with the collective unit, a Clinical Psychology position informed my ethnographic, impressionistic observation of the couple's problems (see p 202-203). During the first of three intake sessions, it became clear that the couple were experiencing psychological problems at an individual level in conjunction with and largely due to relationship discord. While I interviewed them together as a couple during the first intake session, I scheduled two subsequent individual sessions for each partner thereafter. This is a technique used by many traditional couples

psychotherapists and formed part of my personal training as a clinician with couples therapy. In this manner, both private-individual and public-dyadic levels of observation were accommodated. This is useful since many patients are not sufficiently comfortable with voicing certain issues or concerns in front of their partner. This was particularly so in this unique case and further exploration at the individual-private level seemed necessary in order to formulate a complete clinical picture.

After completing the first intake session I decided to consider this particular couple referral as a potential case study for this research project since both partners seemed committed to the therapeutic process and wanted to stabilize their relationship, and fulfilled the other selection criteria outlined earlier in this chapter. In their individual intake sessions I therefore also asked their permission to use any therapeutic material for supervision and professional research purposes (as outlined earlier in this chapter) to which they both agreed. I however awaited their final commitment to the process once they had completed the ethnographic observation procedure discussed below as their issues were indeed complex and multifaceted.

**c) Co-operative Inquiry with Co-therapists**

It seemed therapeutically useful, therefore, to extend the ethnographic observation phase by including the services of two other psychotherapists who agreed to work with each of the partners at an individual-private level for a minimum of three sessions each. The three of us then engaged in a group discussion which was methodologically isomorphic with co-operative inquiry (co-inquiry) research procedure in Discursive Psychology (see Couple - Session No. 1, p 211). This followed their completion of the three diagnostic observation sessions and provided the forum for mutual feedback, co-ordination and planning. This clinically orientated discussion provided divergent story-lines and positions on the couple's difficulties informed, of course, by our positions as psychotherapists in terms of both social and personal identity.

I hoped to show through this method that by working together as a supportive team of co-therapists with the couple at both the private-individual and public-dyadic levels, it would improve the chances of assisting the couple to work through their problems as a dyad. In particular, I referred the male partner to a psychotherapist who was very experienced with neurological problems and their psychological effects since the patient had suffered a severe cerebral haemorrhage some four years previously as I did not have the same level of clinical experience with neurological disorders. Furthermore, the female partner's personal psychotherapist had a great deal of clinical experience working with individual female patients and I had not had this specific exposure to the same extent. I therefore hoped that the two co-therapists would not only provide ongoing support for their patients should this be necessary, but their clinical positions would inform my position as a couples

psychotherapist in this complex and difficult case. This procedure allowed multiple therapeutic positions on the couple's issues to emerge; through exposure to other therapeutic views on the couple, I was able to transcend the limitations of my own clinical discourses on the subject matter, on the one hand, while also gaining access to private-individual level issues between the couple that would otherwise not have been available to me except through the initial separate interviews and some of the paper and pencil tests described in the section directly below. In this manner, I was given important therapeutic clues that I could use when working alone with the couple.

I formulated this procedure in response to my initial observation that the level of trust and mutuality was extremely low between the two partners. Moreover, both had been through a great deal of trauma at the personal-individual level, beyond the dynamics of their relationship as a couple. Each partner could therefore consult with their own personal psychotherapist while I would only ever consult with them together as a couple both during the course of the couples work and at any time in the future.

My co-therapists were associate members at my private practice and we had used this therapeutic procedure as a formula on numerous occasions when dealing with complex, interpersonally orientated psychotherapies where therapeutic 'alliance' positions may have interfered with optimal therapeutic process; that is, 'neutrality' from the couples psychotherapist, for example, is required in order to be most effective in bringing people together as intimate partners since 'siding' as a form of therapeutic positioning with one of the partners (forming an alliance) usually has negative therapeutic outcomes since one of the partners feels blamed for all of the relationship problems and simply assumes a counter-position so to refute this positioning in some manner while the *relationship* continues to deteriorate.

However, the couple chose not to make use of the services of their personal psychotherapists once dyadic work was underway except at the close of the couples psychotherapy when the female partner decided to continue with her own individual psychotherapy but with a psychotherapist closer to home as she lived some distance from our consulting rooms. This procedure was useful not only as a data collection technique but also ensured that I maintained therapeutic neutrality and was not forced to align with one or other party should individual-private issues require focus, which initial clinical observation clearly indicated as a pregnant possibility.

A few days before the case discussion each co-therapist was given a typed questionnaire drawn up by me which very briefly asked for a full DSM-IV diagnosis as well as an outline of possible psychotherapeutic focus for their respective patients. I used this technique as a way of generating further discussion and motivating my co-therapists to formulate clear ideas before the discussion.

During this case discussion, therefore, issues pertaining to diagnostic classification of each partner as well as the distillation of important therapeutic themes which the team believed should be a focus of therapeutic attention were considered. These clinical aspects are discussed in detail in Chapter 8. There would have been sharing of any pertinent information between all of the co-therapists concerned at any point during the therapeutic process should either partner have chosen to continue consultations with their personal psychotherapist.

On the whole this therapeutic strategy worked very well except for a few practical coordination difficulties with regards to the co-therapists' time and the full commitment to the process of one of the co-therapists, who arrived unprepared for the meeting; fortunately I was able to adjust to the situation while ensuring the achievement of my therapeutic goals (see p 211-212). The couple however were a little disorientated at first and complained that the whole procedure was taking too long. I therefore spoke to them both on the telephone during the month or so the co-therapists' were engaged with the weekly ethnographic observation sessions in order to assist their understanding of the reasons and rationale for the procedure. While these had been explained to each of them at the close of their individual intake sessions with me, this had to be reiterated once again during their first dyadic session (see p 238-241) following the co-therapists' case discussion. Furthermore, this procedure was costly and would be difficult with couples with limited financial resources.

The procedures outlined in this initial therapeutic-research phase are, it needs to be emphasized, all based on *ethnographic observations* since it is the perspective of *clinicians* in a clinical context as they attempt to construct a clinical picture of the couple's problems that is most essential to this first deconstruction exercise. I had yet to identify the couple's positions on their own problems. In total, we completed 18 couple therapy sessions over a period of approximately 5 months.

**Account Analysis**

My initial ideas for research and psychotherapy with the dyadic unit were quite impractical given their breadth and inclusiveness. Guided by grounded-theory research principles, I therefore needed to adjust my research procedure as new information became available through the co-operative inquiry process. For example, I had intended to include the Thematic-Apperception-Test (TAT) in order to illustrate the use of this mainstream projective device and demonstrate its possible account and action analysis applications for discursively orientated diagnoses and treatment. However, the male partner found the paper and pencil tests very frustrating and felt overwhelmed by the volume of diagnostic material which was partly a function of his neurological anomalies, it seemed. Furthermore, both partners were already confused about the co-therapy approach and wanted to speed up the process. Finally, the co-therapist feedback also suggested a more streamlined approach, where breadth of

analysis was replaced with clear, concise and focused clinical discourse given the male partner's concentration and memory difficulties (see p 215). It was therefore necessary to streamline the account and action analysis phases by excluding any procedure which might exacerbate their dissatisfaction - the TAT was the first to fall, therefore, since it would have furnished useful but not essential clinical and research information. That is, my intention involved each partner completing an imaginative written response to the TAT cards, each representing some ambiguous social scenario. This is a standardized and frequently used projective technique based on psychoanalytic ideas and its story-telling focus seemed interesting from a discursive clinical position. This information was to be informally analysed and used by me in the selection of rep-grid topics and integrated with the ethnographic observation material collected. In this manner it would have been possible to demonstrate how a traditional clinical assessment instrument can be integrated with discursive techniques. The TAT would have provided a fresh methodological position as to the nature and content of the discursive metaphors available to the couple at an individual-private level. In this way, submerged discursive themes which had not been apparent previously would be identified and made explicit while reinforcing discursive story-lines already identified. Unfortunately this demonstration will have to wait for another research study given the unique dynamics of this particular case study.

**a) Repertory-grid Work**

The clinically orientated rep-grid modeled for the collective unit case study was used along with a specific set of topics abstracted from the ethnographic observation procedure with the couple. The rep-grid procedure allowed the couple to reveal their private-individual constructs of their situation, from the 'inside', as it were, within the confines of public-dyadic space since they completed the questionnaires together in the same room but privately, nevertheless. Their rep-grid topics included the following: conflict; anger; anxiety; vulnerability; trust; living arrangements; children; parenting; servants; illness; sexuality; previous lovers; financial matters; stress; the past; the future; ex-spouses; the opposite sex; sharing; the same sex; having fun; uncertainty; being alone; intimate partners; rejection; caring and support.

The male partner finished his rep-grid responses in two separate sittings since he was not able to complete the task in the three hours it took his female partner to complete the full battery. He became very frustrated in both sittings and felt that the questions were unnecessary, especially the final question, Section C, which he felt should have been obvious from his responses to Section A and B. I explained the rationale behind the test format but I'm not sure he accepted my explanation as his closing comments on the rep-grid show. Please refer to Couple - Session No. 3 (see p 254-272) for a full transcription of the rep-grid responses including his remarks.

**b) Q-Method**

Again the intended direction and specific use of this discursive research technique was impractical in light of the unique therapeutic requirements of this case. An overview of the intended process looked as follows: firstly, I wanted to construct a series of moral dilemma stories around central, mutually contentious themes. These would include a limited range of moral possibilities (i.e. a 'Q-Set' of 'Q-Items') around the moral dilemma in each story. These were to be written down on Q-cards (perhaps 50 cards) constructed on the basis of the rep-grid responses together with any other information already collected. Each partner would be asked to complete a Q-Sort of Q-Items after reading the short moral dilemma. The whole 'moral dilemma Q-Method' approach would have been completed in one session. Thereafter a computer generated analysis identifying degrees of mutual agreement in relation to each partner's respective Q-Sort would be printed out. This would be followed by an account analysis of the agreement correlation findings with the couple in a few further sessions and integrated with mutual problem solving around each issue as it affected their actual relationship. Each Q-Method cycle would therefore have taken between two and four sessions to complete. The benefits of working with metaphor and structured moral dilemma exercises were discussed previously in connection with the family unit - the same arguments apply here, therefore.

This procedure was however not sufficiently focused for idiosyncratic needs of the couple (as discussed above). I therefore simplified the method drastically by developing one Q-Set of thirty Q-Items, based on the discursive themes abstracted from the rep-grid responses which had *direct* bearing on their life together as a couple - no metaphorical constructs were used. I deliberately focused on themes that were contentious and phrased each question as a moral statement (see Couple - Session No. 4 p 274-275); for example, "If one has hostile feelings towards your partner, you should conceal these feelings". I also included reconstruction possibilities in some of the Q-Item statements in order to ascertain the couple's potential uptake of these ideas; for example, "A loving partner will happily let their partner take their temper out on them."

The partners sat together in my consulting room and privately distributed the identical Q-Set of thirty Q-Cards between three different containers marked 'positive', 'neutral' and 'negative'. Thereafter, each partner was asked to place the Q-Cards in order from the 'most to the least' from each container category. This was done by first arranging and then sticking the Q-Cards onto three separate A4 sized sheets of paper, each representing three vertical columns, 'positive', 'neutral' or 'negative'; that is, the Q-Set was arranged finally from most to least positive, neutral or negative, within each column. I guided the couple carefully throughout the procedure. The couple finished this exercise within the 50 minute session and although the male partner finished after the female partner, he seemed comfortable with the activity and made no comments indicating any malcontent this time.

I then took each partner's Q-Sort and entered them as data into a computer program the design of which I had previously commissioned from a computer programmer. This program correlated the partners' Q-Sorts along dimensions of 'Agreement', 'Uncertainty' and 'Disagreement' in relation to each Q-Item position within the Q-Set. It took about 20 minutes to enter the information into the computer and generate an agreement correlation printout (see p 273-275). In this manner, a very clear picture emerged as it was understood from the 'inside'.

**c) Informal Account Analysis**

Please refer to my discussion of informal account analysis with the family case study earlier in this chapter; the same methods were applied and can be found throughout the couples therapy transcripts.

**Action Analysis**

I had intended at first to escalate conflict between the couple in relation to the Q-Method agreement correlation printout by facilitating debate about the various areas of agreement and disagreement during each hypothetical account analysis cycle described above. Here the focus would have been on 'How?' the two parties were interacting with one another. I would have facilitated an action analysis conducted by the couple of videotaped sessions of their debating process in the account analysis procedure. This would have involved an additional one or two sessions and integrated with the account analysis cycle already outlined; a full account and action analysis cycle together would have involved approximately 3-6 sessions. However, there were constant day to day problems arising between the couple that required immediate and direct attention although the method may have worked well in another case with different discursive practices and concerns. I therefore adopted the following approach with this particular case:

**a) Action Analysis in the Therapeutic Process (informal)**

I therefore adjusted this intended action analysis procedure by, firstly, highlighting their mutual interaction during the process of day to day problem solving, both in the psychotherapeutic context (see p 468 and 524, 528-531) and in the broader context of their lives together as a couple (see p 469-488). The couple were therefore encouraged to analyse the process of their own interaction at salient points during the therapeutic process, while I also gave my interpretation of their interaction cycles from my position as psychotherapist (see p 468-488). Furthermore, *conflict escalation* is helpful for an action analysis in the ethogenic sense (see Chapter 4) and is also used from a systems-theoretical perspective as a therapeutic technique (see Chapter 5); my roles as psychotherapist and discursively oriented researcher were reconciled within the limits of this particular case study, especially as this action analysis procedure is easily reconcilable within a systems-theoretical position in terms of its

primary tenets which center around interpersonal *interaction* mechanisms and processes (see p 468-488).

**b) Moral Dilemma Exercise**

A more structured action analysis isomorphic with the intended method was however also included by using one moral dilemma exercise integrated with role playing towards the end of the psychotherapeutic process. The moral dilemma role play exercise occurred during one session (see Couple - Session No. 15 (p 449); see role play specifically, p 499-506) and was followed by a subsequent session where the couple viewed themselves role playing on video (see Couple - Session No. 16 (p 508)), during which I facilitated their own action analysis of their role play (see p 513-523). The moral dilemma story comprised central, contentious discursive story-lines abstracted through the whole therapeutic procedure but repackaged as another story. The female partner appeared to find this method useful since it highlighted the 'performance' aspects of the relationship; this meta-level awareness of process beyond content seemed to enable her to gain a realistic perspective on the relationship and make deliberate, informed decisions (see Chapter 8 for details).

**2) RECONSTRUCTION**

**a) Systemic Couples Therapy**

The day to day interpersonal problems experienced by the couple were worked through over approximately five months and included 12 sessions (see Couple - Session Nos. 5-16) which included systems-theoretical psychotherapeutic techniques and procedure to promote their togetherness as a couple. While this reconstruction process was underway, the initial agreement correlation printout was used as a conceptual map to assist the 'navigation' of this complex activity. It was therefore possible to position myself in a premeditated, deliberate and decisive manner and use the agreement correlation concept map as a navigator might use a star or road map. I could therefore assume a position within their shared discursive space and facilitate both reconstruction therapy and an action analysis, simultaneously, given shared techniques and principles (discussed above) in an informed, intentional manner.

I used the Q-Items which indexed central relationship problem areas and a few potential resolution suggestions as a way of structuring the problem solving process to begin with; that is, by considering, firstly, Q-Items where there was agreement (dubbed metaphorically during therapy as 'green' light areas) and then slowly moved on to discuss more contentious Q-Items ('orange' and 'red' light areas). Indeed this 'traffic light' metaphor was presented together with the agreement correlation map by shading in the respective red (disagreement), orange (uncertainty) and green (agreement) light areas

in these specific colors. This shaded concept map was given to each partner for their personal use along with a full record of all the Q-Items and their respective positionings one to another for each respondent and in relation to each partner. The formality of this structured presentation of their relationship was offset by using playful discursive icons in order to represent the respective dimensions in the analysis; that is, a hat (male) and bow (female) were placed above two circular faces (side by side), while the mouth in each face indicated disagreement (down turned), neutrality (straight line) or agreement (upturned). I used these simple metaphorical images to both consolidate the ideas contained in the structural analysis in a manner that would facilitate easy recall and identification, and also to relax the couple so that they might be more amenable (less defensive and adversarial) to working through their differences given a lighter, relaxed interpersonal atmosphere. I kept another identical copy (which was both visible to the couple and in easy reach during each session) to which I referred from time to time or onto which I wrote further notes as the therapeutic processes unfolded (see p 273-275 for a full copy of the handout, including the map and Q-Items).

**b) Mediating Communication and Conflict Resolution Skills**

I also mediated communication and conflict resolution skills for reconstruction purposes; the couple were taught various interpersonal discursive skills (the same as those outlined in the collective unit) in order to assist them work through their interpersonal differences (see Chapter 8).

**c) Eclectic Methodology**

All the techniques typical of traditional systemic couples therapy as well as some other intervention techniques from other schools of thought were integrated together to assist the couple reconstruct their interpersonal world according to their self-reported goals. These various techniques were chosen and utilized given the needs of the therapeutic moment and are discussed in Chapter 8.

**3) EVALUATION**

My intended means of evaluation initially involved the re-administration of the most contentious Q-Sort in order to compare how their interpersonal discursive constructs had changed both in relation to each other and themselves as individuals. However, the whole therapeutic process came to a rather sudden and unexpected end when the female partner decided to leave the relationship. This occurred after giving the couple an informal evaluation summary of their interaction over the whole therapeutic process as I perceived it as psychotherapist during feedback to them in Session No. 17 (p 524) (see my evaluation specifically, p 531-547); in short, the couple's progress during therapy suggested that their marriage and reconstituted family plans would be unrealistic and highly difficult

for them to realize together as a couple, and I therefore suggested a number of alternative options, one of which was terminating their intimate relationship and any future plans.

During the following session (Session 18, p 547), the female partner informed me that she felt that continued couples therapy was no longer necessary since the therapeutic process had successfully achieved her goals by clearly outlining why the relationship was not working and what was needed to improve it. She felt that any long term improvement would require far too much time and effort, especially given that she saw clearly for herself that the prognosis was poor for any potential marriage and reconstituted family plans (see p 554 and 588). During the last session (Session 19, p 571) she decided to enter into individual therapy and work through her own problems before attempting another relationship (see p 582-593). The male partner disagreed with her as he believed that the couple should attempt first living together before making a final decision to split up (see p 554-555). He however simultaneously admitted to wanting a more carefree lifestyle unencumbered by marital responsibilities (see p 587-588). Furthermore, he also felt that any reconstituted family may be potentially too complex to resolve effectively under any circumstances (see p 591-592). Albeit that I encouraged the couple to consider alternatives to traditional marriage in order to accommodate their relationship idiosyncrasies (see p 547), the female partner remained resolute in her decision (marriage or nothing!) and I therefore terminated therapy with the couple after careful evaluation of their respective positions and the therapeutic process as a whole.

All considered, I understood the therapeutic intervention to have been highly successful especially given the complexities of the case (see p 228). The female partner had initiated the intervention process due to her severe emotional distress over the relationship problems. On termination, she felt suitably empowered through the therapeutic positioning process to make clear, deliberate and independent decisions over their relationship issues with which she had been unsuccessfully struggling for three years:

> *"Ronel: Um, you must remember where I was at a stage, it is different to where I am now ... where I've grown to now. I am at peace with myself."* (p 588)

The male partner had agreed to couples therapy given his partner's initiative and seemed disappointed that their relationship plans had not worked out as he had envisaged. He however did seem clearer as to his positioning within intimate relationships generally although his fundamental positioning and story-lines in relation to his partner seemed to have changed little through the therapeutic intervention - indeed this was the primary reason for his partner's decision to terminate (see p 585); for example, the day after terminating couples therapy he phoned me to ask if he should make contact with his ex-partner immediately, or give her more time before phoning her. This was

because he usually found that she was more responsive to him when wooing her back if she was left alone for a while (see p 593). The clinical implications of this therapeutic outcome are discussed in detail in Chapter 8.

Other ad hoc evaluations initiated by me or the partners also took place throughout the therapeutic process. This allowed me to ascertain the partners' experience of the therapeutic process and adapt or adjust my position as necessary while also keeping the couple informed of my perceptions and concerns as therapist (see p 457, 468, 485-488, 493-495).

**III. Individual Unit**

**1) DECONSTRUCTION**

**Ethnographic Observation**

This was an unusual case study since the ethnographic observation phase didn't follow the pattern typical of Clinical Psychology. This was largely because I first met the patient outside of the psychotherapeutic consulting room at a dinner party some three years before beginning the research. I had been invited to a dinner party by a colleague of mine from the community clinic where I was working at the time and the individual unit patient, an uninvited guest, had arrived together with another invited guest, his very close friend and flat-mate of many years. During the course of the evening, both the individual patient and his friend spoke at length to the company at large, the former particularly. I had interacted as I understood a guest might at a dinner party where I knew nobody except for my hostess and where the other guests were more or less acquainted. I was fairly reserved although it wasn't long before the company had identified my profession and my relation to the hostess.

The individual unit patient had talked a great deal and indeed monopolized the conversation for much of the evening. The rest of the company had been good humored about this as he was on the whole fairly entertaining but more importantly, he introduced himself as a certified mental patient on a disability grant and in need of assistance. This social presentation was certainly unusual in my customary social circles and I found his social positioning maneuvers most interesting; I wondered at the time about the relation between his social positioning tactics and his so-called 'psychopathology' and thought how illuminating further investigation would be. I noticed, for example, that he tended to oppose any active solutions offered in relation to his myriad life problems by the other guests, his friend or myself. The atmosphere was playful and indeed the interaction between the patient and the guests became a little like a 'party game'; that is, the individual patient and all his self-confessed life

problems at the center, while the other guests competed in assisting him in finding the illusive solutions to his life problems. I had taken part in this interaction by pointing out that the patient seemed to oppose any solution once it was given and demonstrated this by using paradoxical techniques from a strategic systems-theoretical position; that is, I would suggest the opposite course of action suggested by another guest only to find that the patient embraced the solution (the obverse of my suggestion) although he had previously rejected it when it was packaged as a directive. The patient and the other guests said that they had found my demonstration amusing and enlightening. The 'game' had come to an end shortly thereafter although the patient continued holding the floor with detailed descriptions of his tortured and miserable life as he understood it.

Thereafter, the patient's friend had approached me privately towards the close of the evening, and had spoken briefly of his concerns for the patient. He also told me in confidence that the patient had been classified as suffering with a 'borderline personality disorder' by psychiatrists and his condition was not improving, if anything it was becoming progressively worse since, unfortunately, neither he nor the patient had the financial resources to pay for the patient's psychotherapy. The patient was therefore being treated through state psychiatric facilities with psychopharmacological intervention. I had left the dinner party along with most of the other guests shortly after this conversation during which time I had mostly listened and suggested a few government agencies which may have been able to assist the patient with psychotherapy. I never met the patient or his friend again and only heard a few cursory reports from my colleague (the hostess) about their life together during the ensuing years.

Three years after this first meeting I deliberately contacted both of them telephonically (through my colleague) in order to request that the patient partake in this clinical research project since ideally, I needed a research candidate who had been diagnosed as having a 'borderline personality disorder' for the reasons discussed earlier in this chapter. The patient therefore provided the ideal research candidate since apart from his lack of financial resources, he fulfilled all the other selection criteria.

My telephonic discussions with both the patient and his friend revealed that the two men were living separately due to the friend's retirement and limited financial resources. The patient was therefore living in a psychiatric half-way home which was affiliated to the large state mental hospital where the patient had been a regular inmate since his early twenties. He was now forty-five years old and his psychiatric problems had continued unremittingly for some twenty-five years. Both the patient and his friend were therefore grateful that I was offering my services free of charge and that the psychotherapeutic focus was new and innovative since no method had 'cured' the patient as yet.

On the basis of information generated through these initial ethnographic observation telephone discussions and the social gathering with the patient and his friend three years previously, I decided to present our interpersonal interaction as 'research' and not as 'psychotherapy'. However, I did indicate that it was possible that the research project might result in healthful change but that this was not my major concern. Rather, together the patient and myself would be applying ideas from a new school of thought to the patient's unrelenting life problems in a formal exercise that was not designed exclusively to effect a psychotherapeutic cure. While this framing was certainly congruent for the most part, I deliberately framed our co-operative inquiry project as 'research' rather than 'psychotherapy' since my ad hoc observations suggested that the patient was very threatened by the idea of 'getting well', so to speak. I therefore thought that an extended metaphor describing our whole project as research activity would be less threatening for this particular patient and may indeed expedite our co-operative inquiry project into liberating his life story from the shackles of psychiatric positioning. Furthermore, from my initial ethnographic observations at the dinner party and further telephonic discussions, it became clear that the patient enjoyed being at the center of attention; this strategy allowed the patient to be the focus of attention since the examiners of this project and any future reader would indeed have a first hand glimpse into the patient's disturbing life - he was grateful that he was able to tell his unhappy life-story to such a learned audience.

I worked with the patient over a period of six months and completed twenty sessions in total, including one session alone with the patient's close friend and one conjoint session the two companions together, before our co-inquiry project was terminated.

**Account Analysis**

It is important to note that in the individual case study unit, the analytic boundaries between the various research phases were even less clear than in the other two case study units and indeed de- and re-construction aspects occurred simultaneously as did account and action analysis procedure in many instances. What follows below, therefore, is an *analytic* formulation of the procedures involved and does not describe the actual process of the research but rather the primary elements involved over the whole research process.

**a) Unstructured Interviews integrated with Grounded Theory and Life Story Research**

The account analysis began in Session No. 1 (see p 596) with an unstructured interview by asking the candidate questions about the details of his life and his personal history, in particular his family relations. Laddered 'Why?' questions, an ethogenic technique, were interspersed with more structured questions prepared before hand based on information emerging from the ethnographic phase procedure, and further adapted during the interviewing process according to the patient's

responses as they emerged in the clinical setting in keeping with the principles of grounded theory. Furthermore, a general reflective, non-directive client-centered approach was adopted as is customary when conducting life story research, another Discursive Psychology method which was interwoven with the other methods; that is, although process notes were made that informed the content and process of later questions and focus, the patient's life story, as understood by the *patient*, was the central research concern here.

This integrated approach illustrates, therefore, the use of ethogenic as well as discursive methodology and method in clinical work. It also shows how client-centered counseling techniques, a traditional, mainstream psychotherapeutic approach, might be integrated with techniques from discursive social psychology. These interviewing principles were used by me during all of the sessions conducted together with the patient as a methodological substrate, as it were, although many other psychotherapeutic techniques were interwoven within this overarching methodology as the needs of the therapeutic moment dictated. These psychotherapeutic techniques, processes and assumptions will be discussed in detail in Chapter Nine.

**b) Repertory-grid Work**

During the second session, the patient completed a short rep-grid questionnaire under controlled conditions. This was conducted privately in the consulting room on his own with no interference from any other party although I was available where any procedural clarification was required. The questionnaire was representative of the standard rep-grid questionnaire discussed earlier in this chapter while the outlined procedure and administration processes also all remained constant.

I intended that the rep-grid questionnaire should be fairly long and detailed however I was concerned that this activity was fairly foreign to the patient who had not been involved in structured activities such as this for some years. I also had had some previous rep-grid administration exposure with the collective and dyadic unit account analyses and therefore was better able to preempt possible problems. I therefore decided to include two distinctive rep-grids that were administered on two different occasions some weeks apart. There were eleven topic items in this first rep-grid questionnaire which included the following: conflict; anger; the same sex; authority; earning a living; the opposite sex; religion; the past; the future; responsibility; fun (see Session No. 2 (p 615) for response details). I deliberately included topics for this first administration that were not too threatening or challenging for the patient so that he might become more familiar with the process. The patient completed this first questionnaire within the session and all sections were completed. I then attempted to facilitate further informal account analysis of his responses using the interviewing methodology discussed in section a) directly above. I had intended to work quite systematically

through the topic areas in this manner however the patient had strong needs to simply talk to someone and express himself. After a few unsuccessful attempts to work in a more structured fashion, I decided to rather keep the rep-grid responses available during each session and where the opportunity presented itself within the patient's flow of discourse to engage in further account analysis of any specific topic. The information this process generated was rich and psychotherapeutically meaningful in my opinion (see p 659-674).

Some weeks after this first rep-grid exercise I requested that the patient complete a second rep-grid questionnaire which consisted of items that I believed to be more challenging for the patient and included the following ten topics: anxiety; sadness; living arrangements; medication; sexuality; intimacy; achievement; uncertainty; being alone; caring and support (see Individual - Session No. 10 (p 753) for response details). In this particular battery, the patient did not complete all sections of the questionnaire. However, his omissions were discussed together with him in further account analyses which furnished important discursive material (see p 782-4).

**c) Assisted Autobiography**

On the basis of the information gathered in the research process I created a short anecdotal story (see p 838) covering emotions and story-lines that had only been touched on or suggested briefly by the patient during the account analysis phase. This is a form of assisted autobiography used in ethogenic account analysis. In this particular case, story-lines pertaining to 'happiness', 'self-efficacy', 'self directed' constructive activity were overshadowed by story-lines suggesting the opposite of these discursive themes. Assisted autobiography was used, therefore, to facilitate both research as well as psychotherapeutic goals since the patient was able to consider latent story-lines which had not been fully adopted as a position by the patient (see p 839-849). In this manner, a more comprehensive account analysis could be completed by conjoining both ethogenic and discursive research approaches since the discourse generated around the assisted autobiography exercise was integrated into the interviewing procedure described above for each session. In this case I demonstrated the solo construction of alternative story-lines rather than working within a research team as is the usual procedure with the assisted autobiography technique. I did this in order to illustrate how a therapist might work alone since in clinical work with individuals, most psychotherapists do indeed work alone and, furthermore, team approaches were illustrated in the other case studies.

**Action Analysis**

**a) Reflecting on the Transference Relationship**

The action analysis occurred concurrently throughout the account analysis process as in the other case studies; that is, the way the patient interacted with me suggested 'How?' he managed his interpersonal life in relation to positioning efforts within his primary story-lines. Although this is not necessarily generalisable to *all* extra-therapeutic contexts, it indeed seemed to comprise important meta-level rules of interpersonal action to which the patient subscribed. By reflecting these back to the patient in typical psychoanalytic fashion, the ensuing discourse could provide further rules of action as well as mediating a higher order level of awareness, one of the principle goals of a discursively orientated psychotherapeutic analysis (see p 960-7).

**b) Self-observation (video recordings) of Therapeutic Discourse**

Videotaped sessions of the patient's therapeutic discourse were shown to the patient where he was asked to comment on the *process of his own discourse* within the therapeutic clinical context. During one of the earlier sessions (see Individual - Session No. 6, p 675) I focused on the patient's abuse of psychiatric medication since it was an important therapeutic issue which needed to be confronted. I randomly went through a few preceding sessions and stopped intermittently in order to point out to the patient how his social presentation was affected by his substance abuse. I deliberately chose a random technique since I wanted to maintain a non-judgmental, co-inquiry approach and I therefore did not select specific recorded portions of the videotapes as I did in the action analyses in the other two case study units. I believed that this approach would be most useful in this particular case study since it maintained neutrality while simultaneously confronted the patient with his own destructive reality. I used this method in order to facilitate the patient's self-awareness of the following discursive practices; that is, his recurrent ways of articulating discourse, the presence or absence of destructive discursive patterns or where new discursive practices needed to be mediated.

**2) RECONSTRUCTION**

It is necessary to outline reconstruction efforts although much reconstruction emerged in the process of and contemporaneously with deconstruction.

**a) Cooperative Inquiry**

Together the patient and I considered ways of improving his life circumstances as he understood them. I attempted to facilitate this exploration process for the patient while also making meaningful contributions of my own. I used the techniques and principles discussed below in order to optimize our co-inquiry. This process seemed appreciated by the patient who indeed found a new name for our

mutual problem-solving focus; that is, as *'co-probers'* we were *'co-probing'* (see p 614) in order to discover ways in which he might more effectively address his myriad life problems.

**b) Perturbing or Unfreezing Fixed Positions and Story-lines**

This involved a discursive meta-level construct discussed by one of Harré's co-contributors, Moghaddam (1999) and Moghaddam & Studer (1998), and also formulated in family systems clinical work which attempts to induce positive psychotherapeutic change by 'unfreezing' or 'perturbing' the patient about possible new positions on story-lines already in the foreground while also suggesting completely new story-lines. This was achieved through suggesting alternatives; that is, deliberately arguing alternative, contradictory or even bizarre positions in order to effect change, the direction of which was finally decided by the patient himself. The technique and manner of application in practice was however diverse and varied and once again relied on the needs of the psychotherapeutic moment and is discussed in Chapter Nine.

**c) Skills Acquisition/mediation**

Within the discursive limits set by the patient himself, I attempted to assist him in identifying potential areas for discursive skills development in order to promote self-advocacy and social and personal positioning for the attainment of his self-defined life goals. The definition of the skill limitations requiring further development and enrichment emerged through the deconstruction process as defined firstly, by the patient himself and, secondly, through the ensuing discourse about skills. Skills related problems were mutually discussed and various solution possibilities suggested, examined and explored (see p 900-1 and 980-982). I also attempted to mediate specific discursive skills where both the patient and I agreed that these would be useful (see p 733). All of the ideas emerging from my position were clearly limited by my own life experience, training and experience dealing with others seeking solutions to their life problems.

**d) Eclectic Methodology**

The methodology used to facilitate reconstruction through mediation/acquisition of discursive skills involved any range of techniques from various schools of psychotherapy. Importantly, however, it is essential to note that the special needs of this particular patient as well as my personal needs from various positions, both social and personal, suggested the use of one or another technique to address the requirements of a particular psychotherapeutic moment. I found that ultimately, in this particular case study especially, this was the only way that a discursively orientated psychotherapeutic intervention could occur; too much planning seemed to result in the imposition of the psychotherapeutic position and compromise the patient's discourse and positioning. These important considerations however had to be balanced with the mediation of new discursive material by me as

well as the confrontation of the patient with story-lines and positions emerging from a Clinical Psychology position within our discourse, for example, the need to limit self destructive behaviors.

## 3) EVALUATION

### a) Evaluation in the Research Process

Most evaluation of the research procedure occurred throughout the research process since the patient would spontaneously appraise our research activity from time to time in one form or another (see p 716 and 825). While these spontaneous evaluations occurred during our sessions and are therefore captured in the transcripts, the patient gave an important spontaneous evaluation during our last telephonic discussion (see Individual - Session No. 20 p 980) when we both agreed to terminate the research process. I noticed that his decision to leave correlated with my decision to stop recording the sessions albeit that I had previously agreed to see him for a further twelve or so sessions in order to complete our contracted arrangement. He however said that he had been offered long term psychotherapy through a government agency and thought that it was better if he terminated with me so that he could begin that process although no definite plans had yet been formulated in this regard. Furthermore, he was again living with his friend as a full time flat-mate contrary to our mutual agreement formulated in Session No. 20 which had attempted to create more independence and autonomy in the patient's living arrangements. Given all these factors, I therefore supported the termination since I had more than enough research material and also felt that I would be pressuring him to follow through on his self-improvement resolutions - I believed that he needed time to work through the issues raised in the research-therapeutic process without pressure from me to perform and, ultimately, he needed to make his own choices. I therefore supported his long term therapy plans since a long term, *supportive* therapeutic focus seemed the ideal follow up strategy to the confrontational approach adopted during our co-inquiry process. It is important to note that the *patient* had initially requested that I use a confrontational therapeutic interaction style (see p 597); it seemed to me, therefore, that his needs had changed and he now required a different therapeutic interaction style. His evaluations of the overall research-therapeutic process were however very positive as his last spontaneous evaluation most clearly testifies (see p 992). These spontaneous evaluations have been integrated with deliberate evaluation procedures (outlined below) and all evaluation commentary is discussed in summary form in Chapter Nine in relation to psychotherapeutic concerns.

### b) Re-administration of the Original Rep-grid

I had intended to re-administer the original rep-grid with a few minor additions in order to elicit the candidate's constructs around the psychotherapist and psychotherapeutic experience. By re-

administering the original repertory-grid, it would be possible to evaluate how certain constructs had changed during the therapeutic encounter while the additions would assess the *perceived* therapeutic cause of the changes as understood by the candidate. I however only re-administered the original rep-grid topics and provided no new evaluation orientated topics since the patient at that time seemed to require stability and focus and any further structured evaluation of the research process may have been disorientating for him. This seemed particularly pertinent because on the whole the patient did not respond well to focused activity of any sort, it seemed, preferring a looser co-inquiry style. I therefore gave him photostated copies of his original rep-grid responses to take away with him to peruse and consider alternatives at his leisure. I hoped that this less directive approach may have been more useful to him and that his evaluation of our research process would emerge through any ensuing discussion about the rep-grids. However, the patient stuck firmly to his original responses and therefore there was not much evaluation discourse generated through the rep-grid revision discussion (see p 921).

**c) Co-operative Inquiry**

I asked the patient's close friend of twenty-five years or so, the most significant person in the patient's life, to give his perspective on the patient's progress in two separate interviews. The first interview (see Individual - Session No. 11 p 757) was conducted alone with the patient's friend mid-way through the research process while the second evaluation session (see Individual - Session No. 20 p 980) included the patient together with his friend at the close of the research process. I also conducted ad hoc evaluation inquiry with the patient's close friend over the telephone from time to time when the patient was hospitalized and unavailable. The evaluations are discussed in summary form in Chapter 9.

## ACTION RESEARCH

The theoretical and empirical research involved in this doctoral project has been most useful as a means of developing my psychotherapeutic skills. The application of Discursive Psychology meta-theory and methodology to Clinical Psychology activity has been an ongoing project since I first began training as a psychotherapist. From the beginning I tried to critically evaluate and integrate discursive formulations within the theoretical metaphors and clinical devices comprising my training as a psychotherapist. It was therefore extremely beneficial for me to able to explore a discursive clinical model through a careful, formal research project at a doctoral level. This research process has assisted me in developing the following clinical resources:

- I have identified a meta-theory which I find very useful in coordinating my clinical activities as a psychotherapist.

- I have identified a formal psychotherapeutic procedure which integrates my new meta-theoretical insights with the practical implementation of clinical methods for positive psychotherapeutic outcomes as reported by the research subjects themselves.
- I am able to maintain loyalty to the moral orders pertaining to my present position as a registered clinician while simultaneously challenging myself to develop more effective psychotherapeutic technology for the well being of my patients.
- I have been able to identify psychotherapeutic and research elements which have been more or less useful in each respective case in a formal manner. I therefore feel more adept and in control of any future psychotherapeutic work. I have found that I am more confident in applying discursive methodology in my day to day work as a clinician and have found that I get the best psychotherapeutic results using the outlined formal model.
- While producing the transcripts in Volume II was a time consuming and frustrating task, I found the process immensely useful since I was able to reflect on my psychotherapeutic skills and interpersonal interaction within the clinical context in a very detailed and considered manner. I was able to reflect on my choice of speech-acts, story-lines and positioning in my clinical endeavors in a way that was unavailable to me previously; that is, without video-recording facilities or the incentive to spend long hours in this self-reflection and evaluation process, I would not have generated the level of growth as a clinician that I believe I achieved through embarking on this doctoral research project.

## CONCLUSION

This chapter reviews the Empirical research process adopted for this doctoral study from both an *analytic* perspective; that is, a formal, abstracted procedural analysis, as well as from a *process* perspective; that is, the emergent, concrete activities, problems and solutions adopted while conducting the actual research process. An effort was made to firstly, adapt the methodological principles involved in discursively oriented research (see Chapter Four) for clinical work and this research project in particular, and, secondly, to simultaneously tell the story of that research process as it actually occurred.

We turn now to a detailed discussion of each of the three case studies from a discursive psychotherapeutic position as opposed to considerations of discursive Empirical research. Chapters Seven, Eight and Nine are each devoted exclusively to discussion of my psychotherapeutic positioning during the case study units; that is, the collective, dyadic and individual level units, respectively.

## Discursive Clinical Analysis: Collective Unit (Family)

Mrs Nina Green took the initiative to respond to my advert in a local community newspaper (see Appendix 3.1 p1016). Both she and her husband (Bill) had tried everything to improve Tom's (9 years old) social and emotional adjustment difficulties since the family's inter-city relocation from Johannesburg to Cape Town a year previously. Their daughter (Meg) of fourteen had adjusted well during this same period and her advice to Tom had also resulted in no improvement. The family had therefore sought professional advice since they were unsure about how to improve Tom's emotional status:

> *Mother: But Mark is it right to teach a child - if children are really nasty and say the child has a funny nose or whatever and they tease him - is it right to teach a child to be nasty back because then they are basically mirroring that other nasty child.*
>
> *Therapist: I hear what you are saying and I think there are lots of different schools of thought on this. I am just mentioning that at the moment Tom is just holding back so much that the guys are being rough with him and he is just not being rough back. What do you make of that, Tom?*
>
> *Tom: Because Howard is a big boy and also Allan is strong.*
>
> *(Edited)*
>
> *Therapist: Dad, what do you think of this whole thing that Meg and Tom are talking about? This whole discussion?*
>
> *Father: (Clears throat). I, um, like to think that he should confront them - to give as good as he gets. That's what I believe.*
>
> *Tom: What does that mean?*
>
> *Mother: Mark, I just think both of us are really battling to give advice to him in this situation. I think we both are. I really battled with all this emotionally.*
>
> *Therapist: But I think it goes right back to the core issue in the family of the feelings of aggression and conflict which we talked about before.*
>
> *Mother: And also you are right. Bill has always wanted to say, "Give him a good punch" but then Bill has always held back because he wonders if that is right advice, hey love?*
>
> *Father: Mmmmm.*
>
> *Tom: I wouldn't do that to a person.*

*Father: Mmmm. (Clearing throat) Fighting isn't always the right answer but my grandfather always said to me, "Count three buttons on a boy's shirt and you punch him there." (Laughter from the whole family)* (p 38)

Please also refer to the clinical diagnostic report (see Appendix 1.2 p 995-999) for Tom's presenting symptoms, and the preceding chapter outlining the diagnostic (research) procedure with the family, while the introductory commentary to the collective unit transcripts (see p 1-2) also describes the family's situation and characteristics as understood from my position.

The goal of this chapter is therefore to formulate a clear clinical diagnosis and demonstrate the intervention strategy used with the Green family based on the outlined discursive clinical psychology model. Quotations from the therapeutic discourse are few and most clinically oriented discussion is indexed by page number to the family unit transcripts (Vol 2: see CD disk enclosed and the beginning of Part II for operation instructions) for substantiation, alternative readings, critical appraisal, disagreement and so on, for the reader.

## DIAGNOSTIC FORMULATION

### DSM IV Classification

It seemed to me that a useful point of departure for a discursive clinical psychology intervention in this particular case was to consider only Tom's symptoms for psychiatric classification in the DSM IV, for two reasons: firstly, his own family had positioned him as the identified patient and, secondly, his symptoms would qualify for psychiatric classification. The story-lines of clinical psychology and the Green family's self-perceived problems (including Tom himself; see drawings in Appendix 1.1 p 994-5) could therefore be assimilated without perjury to the family's position or my own as therapist. This intersubjective interpretation seemed possible if the DSM IV diagnosis reads as follows:

AXIS I: Adjustment Disorder with Mixed Anxiety and Depression, Chronic (Code: 309.28)

AXIS II: No diagnosis (V71.09)

AXIS III: None

AXIS IV: Problems related to the social environment (conflict with peers; no friends); Educational problems (occurred mainly at school)

AXIS V: GAF = 51 (at intake)
GAF = 78 (at termination)

The diagnostic criteria for Adjustment Disorders include:

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s)

B. These symptoms or behaviors are clinically significant as evidenced by either of the following:

(1) marked distress that is in excess of what would be expected from exposure to the stressor

(2) significant impairment in social or occupational (academic) functioning

C. The stress-related disturbance does not meet the criteria for another Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

D. The symptoms do not represent Bereavement

E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months. Specify if: *Acute* - if the disturbance lasts less than 6 months; *Chronic* - if the disturbance lasts for 6 months or longer.

Subtypes include: with Depressed Mood; Anxiety; Mixed Anxiety and Depressed Mood; Disturbance of Conduct; Mixed Disturbance of Emotions and Conduct; Unspecified.

This formulation is clinically useful since it not only allows me to integrate the family's belief systems with my position as therapist, but the psychiatric label (speech-act within the psychiatric story-line) also provides support for the family's perceptions in as much as it acknowledges their concerns as being worthy of treatment and assistance; that is, the family were unsure if they were overreacting to Tom's adjustment problem (intake sessions) or incapable of giving him the right advice (see p. 38-39 and180) or if they should identify an external source (the school) as the reason for his clinical symptoms (see p. 22 and 40) . This diagnosis also sanctioned the family's use of medical aid funding.

It must be noted, however, that Tom's socio-emotional adjustment difficulties were only the focus of clinical concern at the beginning of the therapeutic process. Thereafter I shifted this focus through active therapeutic positioning to other family members adjustment difficulties, so demonstrating their interrelatedness with Tom's difficulties (moving the symptom - a family systems technique). For example (see pp. 180-184 for the full context of this quote)

> Father: I *was hesitant, trepidacious (uses this word). I thought, "Why must we (parents) come here (to therapy)? We are sending Tom here". Then I thought, "No, let's just go and see what the guy (the therapist) has got to say," and I am glad we came because it definitely is a family thing.* ( p. 182)

Indeed by initially supporting the family's story-line, I was working within their rule-systems. This, along with other joining strategies (family systems technique), gave me entry into the family system

despite the father's uncertainty at the outset as to the efficacy of psychotherapy (initial sessions). These strategies were therapeutically useful and this was demonstrated after I asked the parents for reasons why they believed that Tom's symptomatic improvement had occurred so rapidly ( see pp 196-199 for full context of this quote):

> Father: *Mark, if you don't mind my saying so, it is because you have reached ......we **allow**(his emphasis) people, because we trust certain people, we **allow** people to get into us because Nina and I are both listeners.* (p 197)

This entry into the family system allowed me to mediate new story-lines, alternative speech-acts, positions and positioning sequences as well as greater awareness of their social and personal identities in an effort to improve Tom's emotional health as both Tom and his family defined it (see Sessions 8 (p 160) and 9 (p. 180) for the family's definition and evaluation of these healthful changes).

**Discursive Clinical Formulation**

Tom's adjustment problems seem to have emerged due to a disjunction in the discursive practices within his family context and those demanded of him in his new schooling environment with his peers. Tom's descriptions of his peers and their interactions with him suggest the story-lines, speech-acts and positionings of the autonomous world of childhood (see Chapter 3) with its ritual aggression and dominance hierarchy rule-systems (see p 38-40 and p 99-101). Tom, on the other hand, had grown up in what appeared to be a fairly circumscribed discursive community in Johannesburg. There his peer friendships began in pre-school and were closely supervised by his parents who were very protective towards both their children and maintained a tight rein on their social activities. They also always knew the exact family circumstances of each of his good friends and were usually friends with their parents. He therefore had been exposed to a limited range of discursive practices. On moving to Cape Town, Tom therefore experienced an adjustment crisis since he was unable to make friends or be accepted by his peers in his new schooling environment in a manner that was congruent with his expectations and those of his family (see p34-40). It seemed that the family story-lines pertaining to conflict, aggression, assertiveness and confrontation were diametrically contradictory to the story-lines implicit within the autonomous childhood world; Tom simply had not internalized the necessary skills. Any advice from his parents also tended to have negative results since the family's discursive practices could not inform the development of self-advocacy skills in the opposition world (see p 39). However, neither Tom nor any other member of his family were aware of this discursive disjunction or the implications of this reality for Tom's presenting symptoms (see p 198).

His peer group at school were all boys of a similar age to Tom but he felt that he was not accepted by them even though other new boys were accepted into the peer group and seemed happily adjusted (see p 34-35). This situation created great distress for Tom who tended to want to excel in all areas of his life as did all the other family members. His self esteem therefore plummeted as did his sense of his own ability to cope with or improve this highly threatening situation as he perceived it; that is, his personal agency as an individual had been compromised due to changing circumstances and he found himself unable to adapt to these changes and was therefore faced with recurring failures (see p 33-36). His emotional reactions, namely, 'stress' (anxiety) and 'depression' (see Tom's drawings; Appendix 1.1 p 994-5) may be understood therefore as emotional assessments of his perceived ineptitude (self contempt).

From this clinical formulation it seemed clear, therefore, that in order to assist Tom with his difficulties, I needed to promote the development and acquisition of the necessary discursive skills in order to better position him within his peer group's story-lines. In addition, it seemed useful that both Tom and his family should became more aware of the disjunction between the two discursive worlds since each was 'unconscious' (opaque) to the other. Furthermore, it was clear that there were many contradictions within the family story-lines about aggression, confrontation and assertiveness which may have positioned Tom in contradictory moral orders (contempt-honor) within his own family (see opening quote in this chapter; transcripts, p 39).

All of these discourses required explication and re-negotiation both within the family and for Tom in relation to his peer group adjustment; that is, both Tom and the different members of his family needed to enhance their sense of personal agency given Tom's adjustment difficulties and his natural symbiosis within the implicit discourses immanent within his family system - any changes within Tom's peer group relations would be necessarily expedited by familial discursive shifts. By making all of these contradictory story-lines conscious to the various actors, it was possible that Tom and his family could choose to formulate alternative story-lines, positionings and speech-acts through deliberate acts of personal agency which would have an ameliorative effect on his symptoms as he, his family and myself understood them. From my position as psychotherapist, I therefore needed to mediate self awareness and skills development as necessary ingredients of personal agency, while also actively facilitating discursive reconstruction in order to fulfill their expectations of my assistance as a mental health professional.

The remainder of this chapter reviews my therapeutic positioning efforts within the jurisdiction of my mandate as a clinician at the time of conducting the psychotherapy. I will be discussing how I adapted and used psychotherapeutic techniques from the various approaches discussed in Chapter 1

for discursive clinical intervention purposes in light of this discursive clinical formulation. Discursive and ethogenic research techniques adapted as therapeutic positioning 'tools' during therapeutic positioning in this case study are discussed in Chapter 6.

## THERAPEUTIC POSITIONING

### Psychiatric

The clinical report informed the family of the ideas contained in the DSM IV diagnosis of 'Adjustment Disorder' discussed above. No mention however was ever made to Tom or his parents of this psychiatric judgement using the word 'Disorder' or any other speech-act which might suggest dysfunction; using less pejorative speech-acts, the clinical report re-phrased these ideas using traditional clinical child psychology metaphors and story-lines (see Appendix 1.2 p 995-999). Tom's parents accepted this positioning and decided to embark on the therapeutic course of action outlined in the report in order to improve their son's mental health.

The 'ill-healthy' polar pair of moral attributes implicit in the psychiatric story-line was therefore useful since the family could understand their therapeutic involvement as a means of 'helping Tom get better'; that is, as in any illness, treatment should effect the restoration of health. Their necessary involvement in Tom's treatment process seemed to motivate them to cooperate with me as a clinician at the outset of the therapeutic process (see p 197). The father's initial skepticism faded after reading the report given that the psychiatric story-lines and his understanding of Tom's difficulties both correlated; in his opinion, the clinical report 'hit the nail on the head' (see p 1-2 ).

It is therefore possible that the family's perception of my power as diagnostic expert (illocutionary force) may have been partly instrumental in providing the necessary perlocutionary force for the family members uptake of the psychiatric patient role. Thereafter, I deliberately moved the psychiatric positioning into the background, preferring to locate myself in the position of personal growth facilitator within the humanistic story-line (see p 189 and 197).

### Psychoanalytic

So that the parents could become aware of the inter-relatedness of their historically evolving story-lines and positions and Tom's contemporary problems, we analysed the parents' families of origin together in terms of the presenting symptoms. This initially occurred in the last feedback session (unrecorded) before family therapy began, mid-way (see p 112 and intermittent references in Session 6 p 109) through the therapeutic process and in the final session (see p 186-194).

In short, the father reported that his family of origin had been racked with violence before he was 9 years old. His father reformed thereafter although he died not long afterwards. The mother's family were first generation Italians and had also been party to severe domestic conflict although excessive verbal aggression was the primary problem as she understood matters and her parents finally divorced in her mid-teens. She had always tried hard not to be like her mother (vociferous, critical, nagging) with Bill since she desperately feared being rejected by 'a husband', as was her mother (see p 189). She therefore never opposed or confronted him on any matter yet silently resented him on a number of conflictive issues without ever informing him (see p 185-186). At times she had been on the verge of instituting divorce proceedings and had previously sought psychotherapeutic assistance for herself given her contradictory positioning at the public and private levels (information provided during the private feedback session with the mother).

Based on this information, a discursive interpretation linking the parents' socio-historical story-lines with their contemporary family life could therefore read as follows: their aggression filled formative family experiences may have precipitated counter-positioning discursive activity isomorphic with psychoanalytic clinical formulations around the erection of 'ego defenses' (e.g., 'reaction formation' or 'denial') in order to buffer their resulting 'anxiety' in later family situations since their original family experiences provided a primary source of learning for both of them on the nature of 'living-in-a-family'. Similarly, the parents' relocated themselves along the obverse polar position (dialogic) of the same story-line; that is, a possible set of polar pair moral attributes denoting subject positions along this story-line may read as follows: 'chaos-order', 'anxiety-peacefulness', 'discontent-content', 'confrontation-cooperation', 'abandonment-support', 'imperfection-perfection', 'emotional expressiveness-suppression' etc.; that is, perfect order, peace, contentment, mutual cooperation and support in order to counteract their turbulent, chaotic early experiences in their families of origin - the obverse position was implied ('the unsaid') in their formative discourses. Both parents chose to assume, therefore, this counter-position in their contemporary discursive interaction, both with each other and with their children. While their dialogic discursive relocation is clearly an instance of personal agency since both partners had attempted to 're-author' (narrative therapy principle) their experience of family life, the discursive implications of their relocation were not fully conscious to either partner from their positions as a married couple and as parents and, therefore, did not inform *optimal* personal agency. This is particularly pertinent if the rigidity of their dialogical discursive practices is considered as well as the comparative lack of reported contentment on the part of Tom and his mother. Clearly their positional relocation within this story-line had been centrally implicated in Tom's problems as well as in the couple's relationship with each other as husband and wife. Psychoanalytic constructs pertaining to 'the repetition compulsion / return of the repressed' might therefore be reinterpreted for a discursive reading especially since making the discursive

'unconscious conscious' was also central in the overall resolution of symptoms through the family's awareness of the inverted repetition of the parents' respective pasts in their relationship with their children. Tom therefore experienced 'inhibitions' in confrontational situations and tended to be perfectionist and anxious of failure; this was the exact reversal of their experiences as children.

This formulation can also be linked to other psychoanalytic ideas and reinterpreted for discursive psychology. An interesting example is the 'discursive (Freudian) slip': specifically, the 'unsaid' resurfaced in Meg's rep-grid responses to the rep-grid topic, 'Handling Interpersonal Communication'. She chose her parents as ideal models (mom then dad) (section A)) and mentioned two unfamiliar names for people who handled interpersonal communication incorrectly (section B)) and section C) asked for her moral justification for her choices. She made the following associations:

> *Section A) Correct - They don't keep anything from eachother & don't lie. If one is hurt or angry, they would be sure to let eachother know*
>
> *Section B) Incorrect - They are very complexed people and prefer to keep everything bottled up inside of them.*
>
> *Section C) Why? So that you know that what ever it is that you have done wrong, not to do it again.* (p 44-45)

Obviously 'each other' is spelt incorrectly as one word in two places in the same sentence. It is synonymous with a Freudian slip since this manifest discursive error can be unpacked for latent content and meaning. That is, this error is especially meaningful if the following aspects are taken into consideration: the task, her choice of ideal models, her semantic associations in sections A), B) and C), the relation of these responses to the rep-grid topic, as well as her relative lack of errors elsewhere in the rep-grid responses (see p 41-57). All these aspects together seem to corroborate that the misspelling of 'eachother' indexes the primary relationship conflicts discussed by her parents (her mother especially) which are analysed above.

Furthermore, the whole rep-grid methodology can be considered a variation on the psychoanalytic technique of 'free association'. It is therefore possible to understand that both positive (section A) or negative (section B) rep-grid topic responses define obverse discursive positions within the outlined story-line; either may present a possible self location choice. The arguments in this regard are further supported by the other family members' responses to the same rep-grid topic (see p 44-45) as well as the family's rep-grid responses as a whole (Session 3 p 41-57). Indeed, the whole rep-grid account analysis lucidly revealed the immanent discursive structures implicit within the family's discursive practices; through this ethogenic research method their discursive unconscious was made conscious.

An example of another 'discursive slip' which indexes Tom's ambivalence about the family's relocation to Cape Town and his resulting adjustment problems, occurred after I asked him how he felt about being in Cape Town at that moment. He answered by saying:

*Tom: No, I really like it...* (p 4)

He therefore replied both negatively and positively to the question which seems to indicate the simultaneous presence of Tom's 'unsaid', private or submerged self location within the available positions within the family's story-line about their move to Cape Town. This and the other speech-acts which functioned as signals for the 'unsaid' positions within the family's story-lines, could have been discussed using typical account and action analysis procedures, thereby integrating these meaningful anomalies into the overall therapeutic positioning. I chose not to integrate these 'discursive slips' into the process of the therapy since I firstly needed to maintain an age appropriate focus for Tom and, secondly, the family may have found this form of analysis completing bewildering and threatening given the focus on the 'unsaid' and duplicity; their private space as individuals would have been invaded. This was especially pertinent given the family story-lines which tended to sharpen the usual disjunction between private and public discourse in relation to social contempt-honor.

However, another adapted psychoanalytic construct was usefully employed by me in my therapeutic positioning with the family which involved the all important notions of 'transference' and 'counter-transference'. That is, the father missed the second last session due to work commitments and Nina was angry and disappointed about this since she felt that Bill's work always came first (see p 187). The missed session therefore mirrored a recurrent interpersonal situation at home which was 'transferred' from the home context to the therapeutic interpersonal interaction. Together with me, the family analysed the meaning of this 'transference' and linked it to their habitual story-lines, speech-acts and positions. I used the 'transference' situation, however, not only as a means of promoting 'insight' (discursive awareness) into their discursive practices but also as a means for stimulating change within their speech-acts. I therefore encouraged the family to find more effective speech-acts as a way of articulating the new, emerging story-lines and positions which countered their previous, unfulfilling discursive practices. This was achieved through the repetition of real family conflict within the parameters of the therapeutic relationship and situation (see p 161-165). Furthermore, the unwanted feelings of the father were experienced by me ('counter-transference') during the mother's confrontation of him (see p 185-189) in the final session. That is, I experienced transient feelings of sadness, loss and abandonment as the father continually attempted to reject her positioning of him during her confrontation by employing loving and tender speech-acts which of course threatened to render her confrontation impotent; that is, I was able to tune into the 'unsaid'

within their story-line as a relatively neutral, uninvolved third party given the discursive context of their overall story-lines and positioning and the nature and process of their speech-acts. In order to foster my positioning in terms of my therapeutic goals which included assisting the family (Tom and his mother particularly) to confront other people, I made my private thoughts and emotional assessments public to the couple by voicing them and thereby brought a submerged, implicit (unconscious) position; that is, the father's fear of negative evaluation by his wife, into explicit focus which rendered the discursive unconscious conscious once again. The couple thereafter discussed the father's positioning maneuver and the three of us considered together how this information related to our overall therapeutic goals (see p 187-189) - agential efforts at re-authoring more useful story-lines and positions for the family's changing discursive context therefore occurred by synthesizing therapeutic discourse typical of two divergent schools of therapeutic psychology usually distanced from one another; that is, psychoanalysis and narrative psychology, through the application of Discursive Psychology meta-theoretical principles in the context of discursive therapy.

**Cognitive-behavioral**

Problem solving strategies and discursive skills development were mediated to the family members during the course of therapy. In this manner I was able to inject new discursive material into the habitual discursive practices within the family system in order to assist them in moving towards their self defined goals. I specifically timed these activities for later on in the therapeutic process (see Session 7 p 134) since specific skills acquisition was primarily related to the reconstruction phase. I also attempted to integrate the discursive material emerging during the deconstruction phase to ensure relevancy and the family's uptake of the skills mediation during reconstruction.

Meta-level interpersonal communication skills were mediated through me teaching the family to use 'I & You messages' as speech-acts to be applied in any discursive context - home, school or work, for example, so to improve their sense of personal agency with regards to constructive interpersonal confrontation. These speech-acts were written down on a handout (see Appendix 1.7 p 1009) and each family member took a copy home to refer to when necessary. The handout also included a second page outlining an interpersonal conflict resolution strategy - the 'double win' (see Appendix 1.7 p 1010). The communication skills and conflict resolution strategy were used together; that is, two (or more) interlocutors would exchange 'I &You messages' in order to clarify their respective positions and story-lines in relation to mutual concerns which may be generating unwanted conflict. Once their respective positions have been made fully conscious to both parties, the interlocutors attempt to create a situation where each can experience the fulfillment of their respective needs as understood after the process of their negotiation in terms of their mutual concerns; that is, a 'double-win'. These communication mechanisms function as a form of discursive currency between potential

interlocutors and need to be simple, effective and easily taught to a wide range of people if interpersonal communication is to be rendered more effective through their use. Indeed the very simplicity of these interpersonal speech-acts and the conflict resolution strategy is also important in providing discursive mechanisms which can be effectively employed when they are most needed; that is, 'in the heat of battle'.

The method of teaching these generic discursive skills is however different in each case (see p 136-159 for the process adopted while teaching these skills to this particular family). It is important to note that I demonstrated these meta-skills using metaphorical examples, real conflicts within the family (third order positioning) as well as directly in relation to the therapeutic context (second order positioning): I firstly explained the conflict resolution procedure using a metaphor (two people fighting over one orange) which was accessible to all the age groups in the family and managed to convey the fairly complex notion of a double-win simply but effectively. After orientating the family to the idea of the double-win as outlined in the handout (through metaphor), I then asked the parents to role play the conflict resolution procedure. Thereafter each family member, in turn, was asked to think of a real example of interpersonal conflict where a double-win was or could have been used. These first examples were not to involve conflict between the family members. Thereafter I progressed onto discussing 'I & You messages'. In this particular case and given the therapeutic moment, I integrated real conflict between myself and the father into the first demonstration of these discursive skills (see p 151). Thereafter all the family members attempted to use the skills in context of real conflict between the family members using both role play and direct confrontation.

The therapeutic rationale behind the mediation and use of these communication mechanisms follows cognitive-behavioral therapeutic (CBT) approaches adapted for this discursive project. That is, the outlined discursive skills are mediated through *training* which is congruent with many CBT techniques, as is the emphasis on *thinking skills* as these affect manifest behavior and emotional responses (e.g., rational-emotive behavioral therapy (REBT)). By thinking about communication in alternative ways and by actively learning new speech-acts, the illocutionary and perlocutionary force of this cognitive restructuring on discursive interaction seemed to yield positive emotional assessments for the family members since they were resolving conflict in a manner which was congruent with their aspirant story-lines and positions; that is, to be able to confront one another and other people (e.g., at school, within the marital relationship) about their grievances and find mutually agreeable solutions. The progressive presentation of material from non-threatening, metaphorical issues to begin with through to real, direct confrontation about contentious personal issues, is also resonant of behaviorist techniques such as 'systematic desensitization'.

From a discursive position, however, the 'I & You messages' contained in the handout have been constructed in a manner which isolates and integrates some key Discursive Psychology principles for the attainment of therapeutic goals: firstly, these messages comprise the pronouns 'I' and 'You' which position both the speaker and the listener (Self & Other) in terms of the first speaker's personal and social identity. By alternating the uptake of the first speaker position (Self), these speech-acts therefore make it possible for both parties to become aware of each other's respective positions in relation to the other, given any number of possible story-lines; secondly, the pronoun is followed immediately by a discursive moral assessment (I *feel*....; You *feel* ...) in the form of an emotion word (e.g., *I feel* angry, happy, fearful etc....) which describes the moral position of the first speaker; thirdly, the positioning grammar and moral assessment is followed immediately by positioning the Other in terms of the first speaker's moral assessment by using the phrase 'when you' (e.g., I feel angry *when you* don't listen to what I'm saying...) which clearly defines the exact discursive positions of the interlocutors in relation to each other and the attendant story-line; and finally, by employing a 'Why?' question (because ....?) from ethogenic account analysis (e.g., *I feel* angry *when you* don't listen to what I'm saying *because* a husband should listen to a wife), it is possible for the speaker to elucidate the exact story-line they understand to be relevant during any given conversation. Consequently the meta-level structural sequence of 'I & You messages' might read as follows, therefore:

- clear pronoun positioning (subject /Self)
- moral assessment (emotion word)
- clear pronoun positioning (object /Other) in terms of a specific speech-act within a story-line
- invocation of the overarching story-line linking the pronouns with moral positioning through moral justification.

As meta-skills, therefore, these simple but highly effective speech-acts can therefore gradually be used more loosely in conversation since the meta-level structure can be internalized by speakers through progressive training and then used in conversation in a less formal, less rigid fashion. For example, during the course of a more flowing, natural conversation (comprising various story-lines), a person (Self) may explain how they feel (moral assessment) about their discursive interaction with another person (Other) and provide reasons (moral justification through story-lines) for a particular moral assessment (e.g., see mother's confrontation with father, p 185-195). This is possible since salient dimensions of discourse ('I' indexes personal identity) are at the very epicenter of these mediated cognitive-behavioral skills; indeed it is through the *process* of negotiating discourse in action that new, more self-fulfilling interpersonal interaction cycles are facilitated using these grammatical mechanisms at a discursive meta-level - personal agency is necessarily sharpened

through these discursive mechanisms since the individual is able to articulate their needs more effectively within the flow of social discourse.

Another CBT technique used for therapeutic positioning and the development of agential possibilities was the implementation of REBT type processes within the discursive model; specifically, I helped Tom *understand* the self-defeating nature of using 'avoidance' as a coping mechanism for resolving interpersonal conflict; that is, Tom wanted to develop peer conflict resolution strategies but could not develop these skills if he continually avoided confrontation or conflict (see p 167-168). By using this therapeutic positioning, I was able to motivate Tom into confronting his fears. This REBT strategy was reinforced at the individual therapeutic level where I assisted Tom in encouraging his thinking on how to develop courage by using metaphor and role play during play therapy; in fantasy, Tom entered into confrontational combat with other parties while I assisted him in putting an arsenal of weapons together and in planning his strategic attack (see p 12-19). In this manner I was able to mediate thinking skills about strategic planning, preparation, ritual display of strength etc. which might be applied in other social circumstances, for example, when participating in an actual fight with his peers at school or confronting his father at home.

These thinking skills were mediated by adopting both abstract (metaphor) and concrete (real situations) positions on the CBT story-line vis-á-vis cognition. I was therefore able to promote therapeutic reconstruction with Tom at the individual level using metaphorical argument and simultaneously at the collective level using literal as opposed to figurative techniques. Similarly, the use of metaphor to explain the 'double-win' conflict resolution strategy was also usefully combined with real conflict situations: abstract thinking skills (tenor) emerged as a function of the concrete example (vehicle) of two people sharing an orange or confronting a band of thieves; these meta-skills were further elucidated in their application to real, everyday conflicts - through this dialectic, effective learning occurred for both Tom and his family members which facilitated their moving towards optimal agency within their new discursive contexts.

**Humanistic**

Gestalt, client-centered and existential psychotherapeutic techniques and principles were also integrated with discursive psychology notions to promote my therapeutic positioning in terms of therapeutic goals:

*Gestalt*

Role play was used extensively throughout the therapeutic process at both the individual and collective levels. Dramatic reenactment and experimental theatre are also techniques used in

Discursive Psychology research methodology and this gestalt method could therefore be usefully integrated for discursive clinical work. I adapted the use of role play for the needs of the therapeutic moment and included the following strategies:

- Structured role play:

I constructed a moral dilemma exercise (see Appendix 1.5 p 1004-7 and Session 4 p 58) on the basis of the discursive clinical formulation outlined earlier; that is, briefly, I created a moral dilemma role play involving the disjunction between the rules of conflict within Tom's peer group (Red tribe) and within his family (Blue tribe); these two tribes of aliens each had ten rules which governed their approach to interpersonal conflict although both tribes had lost many members to a third, emergent tribe (Golden tribe), as neither rule-system could be adhered to under all circumstances. Consequently the moral dilemma required formulating 10 golden rules of interpersonal conflict which would limit the number of moral casualties and outcasts from the new Golden tribe - this, of course, involved the development of agential skills through metaphor for all family members.

The process was conducted as follows: the family members were each given a handout (see Appendix 1.5 p 997) describing the aliens situation and rule-sets the day before they attended the planned role play session. This gave them time to think about the moral dilemma and for Tom especially, to fully understand the contents of the role play. I used the furniture in the consulting room as 'props' since the cane chairs were a golden color with reddish or bluish upholstery, and divided the family into two teams. I deliberately placed the father and son together in the same team in order to encourage the development of the father-son subsystem (see systems-theoretical principles) within the family. Thereafter the mother-daughter and father-son teams competed against each other in arguing the moral rectitude of the Blue or Red tribes' rule-systems; the teams exchanged sides and therefore all the family members argued both the Red and Blue tribes' story-lines and positions. Thereafter the family negotiated ideal rules of interpersonal conflict as they understood these after carefully considering the pros and cons of the respective story-lines, thereby conjoining the two primary story-lines into an ideal synthesis.

This provided an important discursive foundation upon which further therapeutic reconstruction could take place for further developing each of the family members' sense of personal agency in relation to coping with interpersonal conflict. This methodology also provided a vocabulary which could be used in later family as well as play therapy sessions in connection with the two divergent story-lines between which Tom was positioned in contradiction (see p 194-195). The role play accommodated all age groups within the family and provided a useful metaphor which indexed the complex structural aspects of the discursive clinical formulation in a simple but effective manner.

- Semi-structured role play:

The transcribed play therapy session (see Session 1, p 3) demonstrates using role play in a looser, less structured manner so that Tom would begin re-authoring his contradictory subject position as he gained a sense of personal agency through the elaboration of his speech-act repertoire, the development of his strategic thinking skills and his ability to contain the relative discomfort experienced during interpersonal conflict and confrontation. By rehearsing through role play, therefore, Tom could begin experimenting with alternative discursive practices and develop a greater sense of personal agency and self advocacy. The role play evolved through initially using two other gestalt techniques, namely, 'expressive art activities' and 'story-telling'.

I firstly asked Tom to produce a spontaneous piece of art (see Appendix 1.3 p 1000) using the assorted art equipment in the play therapy consulting room (see p 3-4) using any technique, media and subject matter of his choice. Thereafter, I briefly used account analysis methods (ethogenic research procedures) to understand Tom's associations to his picture (see p 4) before suggesting that we both tell a story about the picture. He agreed to this and I began the story which involved mountain hobos or *bergies* (Tom had drawn Table Mountain) living in a cave. He continued with the story-telling thereafter and I interrupted him from time to time where I thought the story-line could be altered to incorporate novel discursive elements, over and above those already internalized by Tom; his story seemed to represent or index, metaphorically, many of the emotional conflicts experienced in his everyday life. For example, the mountain hobos paired up with some robbers in order to secure food and then were later double crossed by the robbers. It seemed that the robbers may have represented Tom's peer group while he identified with the hobos (see p 4-8). While the hobos' efforts involved violence and confrontation with the robbers, they repeatedly ended up in helpless positions, for instance, 'being killed' or 'not receiving money when begging'. At these critical therapeutic moments, I therefore changed the story-line by taking up an alternative position within the implied pair of moral attributes within the existing story-line; that is, self advocacy, not helplessness; courage, not fear; confrontation, not avoidance; indignation, not victimization; action, not passivity; personal agency, not the patient role etc.. I therefore, for example, took the initiative to interrupt Tom's story and role played one of the hobos begging helplessly for money. In fantasy, I allowed a robber to pass by the now helpless hobo and this time I modeled extreme indignation (speech-act within a story-line) at the robber's betrayal! This resulted in re-positioning Tom for a full confrontation with a persecutor since I deliberately handed over the story-telling initiative to him at the point of confrontation; he then had to complete the story. His narrative involved a huge fight between the now heroic hobo and the three robbers.

I intensified the therapeutic re-positioning by encouraging Tom to reenact the fight using role play. The three robbers were represented by various balloons blown up to different sizes. Each was given a name and a character. Their names were written onto each balloon next to a cartoon-like picture drawn by Tom of the character with written dialogue congruent for each character (inside cartoon balloons) (see p 8-11). Thereafter, I assisted Tom in putting together weapons and a combat strategy from the assorted aggressive toys in the toy box (see p 11-15). Tom had to then reenact the fight by bursting the balloons ('killing the robbers') with the 'weapons' while simultaneously describing his strategy and the ensuing action. I played the role of the robbers intermittently and intensified or redirected the action as I thought necessary. The balloons were made from very durable rubber and indeed Tom struggled hard to vanquish his fantasy foe, but he triumphed eventually; metaphorically, Tom repositioned himself within discourse in a more self fulfilling manner, thereby taking one of his first steps towards a sense of personal agency in relation to the implicit discourses contained within the autonomous childhood world.

- Spontaneous role play:

During the course of family therapy, I used unplanned or semi-planned role play from time to time in order to reinforce therapeutic positioning given the therapeutic needs of the moment. For example, during the Milanese style co-therapy intervention (see Session 5 p 83), I staged an impromptu role play along with my co-therapist, involving an error I had made the previous session. At our planning meeting we had very briefly considered the possibility of my being confronted by the co-therapist about the error through role play in front of the family. This however was contingent on a given opportunity during the course of the co-therapy session; we had no idea as to how this would actually occur, if at all? I however did manage to spontaneously initiate the role play sequence at the end of the session (see p 107-108) and I believe that it was useful in modeling the speech-acts of the 'confront and be real' story-line so that the family members might create a greater sense of personal agency during interpersonal confrontation, both towards each other and in alternative discursive contexts.

Further spontaneous role play was used by me to role play certain family members' positions (see p 150) during skills training, for example, or as certain submerged subject positions emerged which required fuller explication. For instance, my role play of the 'three button punching technique' suggested by Tom's paternal grandfather for beating an opponent in a physical fight (see p 39). I also directed family members to role play certain parts in order to illustrate a point and given the needs and opportunities afforded by the therapeutic moment. For example, Tom, his father and I role played 'confrontation' with Tom's peers (see p 101-102); Meg, her mother, father and Tom role played Meg's confrontation of her parents as a teenager (see p 102-106); and, finally, the parents role played

the illustrative example of sharing an orange during the 'double-win' conflict resolution demonstration (see p 138).

*Client-centered*

Reflective summaries were used throughout the therapeutic positioning in order to clarify and integrate material covered during sessions, as is typical in client-centered therapy (see p 150-151 and 158-159). This assisted family members in making sense of new and complex material by orientating them to salient aspects and indicating how these informed their daily concerns. Furthermore, the 'I & You messages' discussed above also contained 'feeling and content reflections' characteristic of non-directive, client-centered counseling techniques. These techniques were adapted and integrated with cognitive-behavioral ideas for use from a discursive clinical position and the same arguments apply, therefore, for their integration (see cognitive-behavioral techniques directly above).

*Existential*

On a few occasions I used 'self-disclosure' in order to position the family members in terms of therapeutic goals. For example, I reinforced Tom's non-retaliatory coping strategy with *big* boys (Tom was average size for his age) as one of many possible coping strategies by briefly voicing my experiences at school (see p 100). In this way, I was also able to inform Tom that I too was imperfect, scared, weak etc. during some childhood confrontations but I had managed to survive into adulthood; by implication, so could he. This was yet another means of mediating a sense of personal agency to Tom.

Finally, I attended to existential questions about creating personal *meaning* in life by reflecting the mother's sense of being in an existential vacuum in relation to her role (position) as a woman; given her socio-historical heritage and the contemporary demands of her position in relation to her children and husband (see p 189-190) and her attendant moral confusion thereby positioning her as a personal agent within the confines of her discursive world.

**Systems-theoretical**

Systems-theoretical therapeutic techniques clearly had much to offer my positioning efforts as therapist in this collective case study unit; I therefore used ideas from strategic, structural and Milanese family therapy approaches as well as from eco-systemic interventions:

*Strategic*

The family were very cooperative during the therapeutic process and it was therefore unnecessary to use strategic techniques in order to assist them to reach their self-defined goals. I however chose to

encourage their process of change by using a therapeutic paradox in the closing session with the parents as one way of possibly preventing back sliding given therapeutic closure. Specifically, after the parents had reported considerable positive change within the whole family and Tom especially, I voiced my concern that although I too agreed with their assessment of general progress, I believed that the family had moved too fast and that indeed the quality and level of change was unheard of in psychotherapy. I therefore suggested that they move more slowly and perhaps deliberately regress to their earlier discursive practices. I used the metaphor of learning to ride a bicycle and the attendant danger of falling off due to speed wobbles. The parents argued against this position, of course, and they themselves reinforced why there should be no back sliding; in their opinion, only continued progress was possible (see p197-198).

The content of this strategy was not completely fabricated since I was indeed amazed at the speed of the family's change and Tom's improvement - while I was used to patients improving, I had not witnessed the depth and speed of change presented by this family and child very often in my role as therapist. I was a little concerned, therefore, that the changes may be cosmetic and superficial, especially given this particular family's story-lines around perfectionism and public presentation. I consequently reinforced the strategic paradox by suggesting that weekly play therapy sessions continue concurrent with regular parent guidance sessions every six weeks to ensure the solidity of the therapeutic gains ( see p 199-201). However, apart from three more play therapy sessions, the family terminated the process thereafter and never returned, preferring to continue their growth process independently; I understood this to mean that the therapeutic changes were indeed genuine, although I may still be mistaken.

*Structural*

Since Tom's adjustment difficulties were understood to be informed by the relative incongruence of his peer group's discursive practices and those within his family and, furthermore, since there were submerged story-lines and positions within the family's discursive unconscious which, if brought into the foreground might assist Tom in developing the necessary discursive skills to secure a sense of personal agency within his peer culture, I attempted to harness the father's submerged discursive skills since he appeared to have mastered all the necessary skills for coping with the autonomous childhood world (see p 38-40); that is, I borrowed skills from the father's discursive repertoire to augment his son's perceived sense of personal agency. As such, I attempted to strengthen the father-son subsystem within the family since the relationship boundaries between Tom and his mother seemed enmeshed due to the relative breakdown of the spousal subsystem (see p 29-30). Consequently it was also necessary to strengthen the spousal subsystem through therapeutic positioning; the spousal and parental subsystem boundaries were conflated given the parents'

estrangement as husband and wife (see p 35-37). By engineering discursive interchange through joining strategies between father and son, it was possible that Tom would begin to internalize and use these skills as well. Further, by facilitating the development of more confrontational discursive practices within the spousal subsystem it was possible to reinforce these ideas from an additional level for Tom's growth while liberating him of his mother's attachment to her mothering role given her emotional isolation from her husband. This provided Tom the opportunity to begin exploring alternative positionings in his discursive environment unfettered by his mother's protectiveness. Thus a sense of personal agency was mediated to both Tom as well as his mother in order to effect the amelioration of Tom's psychiatric symptoms

The subsystem re-structuring goals were achieved therapeutically in the following manner, for example: during the moral dilemma role play the father and son were deliberately positioned together in the same team; similarly, the parent guidance sessions positioned the parents together as a subsystem within the family while the ensuing discussion clarified their roles within the spousal as well as parental subsystems (see Session 9 p 180); Tom was encouraged by me to use his father's speech-acts during peer confrontation; that is, the father often used violent images and ideas in his discourse (see p 23) in a humorous manner, which seemed potentially effective within the peer culture as a from of ritual aggression (safe but assertive). Within this same therapeutic positioning sequence I also orchestrated Tom and his mother's confrontation of the father's use of violent language which irritated both of them although they had never confronted him before (see p 111-117 for the full positioning sequence).

These changes occurred through the 'escalation of stress', another systemic technique, whereby the family members were not given recourse to their habitual discursive practices since these maintained the structural status quo. By engineering these changed discursive relations within the family subsystems, Tom was able to grow in the direction that both he and his family believed was optimal but were unable to effect given the pre-therapy structural anomalies and their requisite lack of personal agency for addressing these discursive problems.

*Milanese*

Circular questioning, my neutrality as a therapist and some of the other features of Milanese family therapy discussed below were utilized throughout the therapeutic positioning process. These were integrated with Discursive Psychology research methodology and indeed, neutral, circular questioning formed the foundation of my therapeutic interaction with the family. Please refer to Chapter 6 for details and Sessions 2 (p 22 ) and 6 (p109) for illustrations of this important methodology for effecting discursive therapy within collectivity.

I used Milanese reframing techniques on order to foster my therapeutic positioning; for example, once the family and I had indeed established that Tom was experiencing a clinically definable crisis (clinical report and the stated psychotherapy recommendation), I reframed family 'therapy' as 'education' for optimizing family well being rather than as 'therapeutic restructuring of *family* psychopathology', which indeed is a story-line which was implied by asking the family to participate in the therapeutic treatment (see p 23-25). At this point in the therapeutic positioning therefore, the family understood that they were participating in an educational 'course' of fixed duration (8 sessions), after which they would have learned to interact in more effective ways with each other. I also deliberately linked this to educational courses for staff development in corporate situations so that the father would feel less threatened by the implied 'family pathology' story-line given his corporate familiarity and initial reticence about participating in therapy. Another reframing technique involved reframing certain primary assumptions held by family members in order to assist them in reformulating their emotionology as a family; for example, angry outbursts and demonstrative aggressive displays were reframed as interpersonal 'signals' and not indicative of 'disorder, chaos, abuse etc.' as the family had previously assumed (see p 66).

The Milanese team approach was also useful for therapeutic positioning by providing another perspective on the family. There were some important story-lines and positions within the family of which I was not fully aware; for example, after our co-therapy session, my co-therapist, Dee, pointed out that the family seemed to idealize me and she therefore felt somewhat 'left out' during her therapeutic interaction with the family. She went on to point out that this may be linked to their protective insularity as a family, which was partly why Tom had no friends; you were either 'in or out'. Using a more traditional Milanese reframe, she went on to suggest that Tom was indeed being a 'good boy' for mom and dad since he had no friends and was thereby preserving the family's integrity. While this reframe did not support my overall therapeutic goals since it seemed to blame the parents too directly for Tom's misery and would not in itself effect improved personal agency for Tom, it could be assimilated into my clinical formulation as a permutation. In a later session I therefore did suggest that the parents relinquish some of their protectiveness and allow Tom to explore potential friendships in a less restrained manner (see p 150).

The other co-therapist, David, reflected that although I did make some effort to 'move the symptom' away from Tom to other family members, I focused too much on Tom's problems and did not move the symptom sufficiently for our co-therapy intervention to really qualify as Milanese and, furthermore, he felt that it was unfair on Tom. I however explained that as a discursively oriented clinician I was working within the *family's* story-lines since the whole family, including Tom

himself, understood him to have the problem. I did however agree that moving the symptom was necessary from a clinical position and therefore I attempted to integrate this technique more often into later sessions but only once the family felt comfortable that I had fully accepted their position (see p 89 and 96). I therefore used the family's framing of the clinical problem to inform my therapeutic positioning rather than the Milanese family systems story-line which was rather used in the service of broader, higher order therapeutic goals as outlined in this chapter. I also used a conceptually related technique, 'balancing', which involved moving the symptom, my attention or any blame for the problem from one family member to another in a consistent and fair manner (see p 193-194).

Finally, the team assisted me in monitoring the interaction with the family. This was made clear to me when in a later session I forgot to address Tom after I had promised him that I would address him next during circular questioning (see p 154); this perhaps would not have occurred with the team's presence.

Another useful systemic technique involved reflecting back to the family their analogue (body language, unspoken interactive cues and patterns) as opposed to digital (spoken language) communication; for example, the mother's facial expression of relief after Tom had confronted his father about not continuing to play rugby at school. She was relieved because even though she and Tom had thought that this would offend his father, he fully accepted Tom's decision (p 89). This was useful as a therapeutic positioning device since it opened up a whole forum for discussion and also illustrated to the family their emotional inter-relatedness and mutuality.

*Eco-systemic*

The outlined discursive clinical formulation contains important eco-systemic elements since it assumes that the disjunction between two activity contexts within the eco-system, namely, home and school, was ultimately responsible for the development and maintenance of Tom's symptoms. Indeed his father had specifically asked me at the outset of therapy (see p 22) if I thought that a less traditional, more liberal schooling environment would solve Tom's problems. I responded by suggesting that he make that decision for himself on completing the course of family therapy. On closure his parents decided that Tom's existing schooling environment presented healthy opportunities for his personal growth and development and that changing schools would compromise these learning opportunities (see p 170-172). While the eco-systemically orientated therapist might have assisted Tom in finding a more comfortable niche within the local schooling system, or attempted to engineer links between his home and school life by rallying the support of schoolteachers or older pupils along with regular meetings with his parents, for example, which were

all latent story-lines within the family's discourse, I chose to bridge the gap between the two contexts by assisting Tom and his fellow family members in developing a sense of personal agency in relation to interpersonal conflict as a first therapeutic step, failing which, other avenues would be considered. I did this largely through skills development and by explicating submerged story-lines and positions within the family context in order to bolster Tom's position at school and assist his parents in understanding and coping better with Tom's adjustment problems.

Although I made reference to other eco-systemic contexts during the course of therapy and deliberately indicated that the acquired skills were intended for use by Tom and his family members in a range of eco-systemic contexts (see p141-150), my intervention did not really assimilate eco-systemic therapeutic methodology. Eco-systemic interventions may however have been very useful in Tom's case, especially if my personal agency focus were to be integrated with latent growth possibilities within the broader eco-system of which Tom was a part.

**Narrative**

The clarification of existing personal, marital and family narratives and the development of more fulfilling life stories (re-authoring) through deliberate acts of personal agency, certainly informed my therapeutic positioning efforts in this case study; narrative therapy principles were therefore at the center of my therapeutic positioning strategy. However, I did not limit myself to narrative therapy methodology which primarily involves assisting patients to clarify and re-author their life stories as they understand them - clearly my methodological application was far broader for effecting therapeutic change. I subsumed narrative therapy's higher order therapeutic premises and reinterpreted them according to the outlined discursive clinical model and adopted a host of other therapeutic positions typically distanced from narrative therapy (e.g., psychiatric) in order to effect these overarching therapeutic goals. Moreover, narrative therapy understands the therapist role to be facilitative and non-directive on the whole. I however embraced my role as therapist and rather than attempting to de-emphasize my position as 'expert healer', I used my position of authority to effect deliberate acts of therapeutic positioning and restructuring in order to shift Tom and his family forward for the achievement of their self defined goals; defining Tom's adjustment difficulties as a clinical problem (psychiatric story-line) was the first step towards therapeutic relief work.

I found the narrative therapy technique of story-telling useful at both the individual and collective levels as outlined above in the discussion on gestalt techniques. Furthermore, I assisted the parents in re-authoring their socio-historically evolving story-lines about 'living-in-a-family' and 'living-as-husband-and-wife' (see Session 9, p 180) so that they might find greater meaning in their co-

existence both within their family as parents and together as a married couple through their heightened sense of personal agency.

**Therapeutic deconstruction analysis**

Together, the mother, father and myself cursorily deconstructed the cultural story-lines constructing the family discourses for their illocutionary and perlocutionary effect on their roles as man and wife within the family in an effort to assist their development of personal agency still further through broad re-authoring efforts; that is, we deconstructed the power relations between husbands and wives in relation to social class prejudice and the mother's perceptions of Italian culture (see p 187-195).

## CONCLUSION

After completing the detailed analysis of my therapeutic positioning efforts, I became acutely aware of the many other possible strategies available for assisting the family in promoting Tom's adjustment at school. However the strategy adopted was successful on the whole as the family understood the therapeutic experience to have been useful. I would have liked to explore reconstruction work with the spousal subsystem relationship in more detail but Tom and his mother did not wish to continue since they believed that their reasons for seeking professional psychotherapy were no longer applicable - Tom was much better adjusted amongst his peers at school and was no longer symptomatic. Furthermore, Nina was actively confronting Bill on issues at home so modeling appropriate confrontational discursive practices for her children and she therefore experienced a greater sense of self efficacy with regards to her role as parent. Family relationships were therefore considerably improved given their greater sense of personal agency in relation to the discursive worlds of which they were all a part, both separately as individuals and collectively as a family. Meg had also learned through the therapeutic process to position herself better in relation to her needs as a teenager and those of her parents, while Bill made the following comments outlining the essence of his personal growth as a discursive agent which in turn impacted on the lives of all the other family members:

> *Father: So that has been a change. The school, which was a big issue obviously......I think that has been the biggest one as far as I am concerned. In helping Tom's decision with the rugby, which was a big stumbling block...*
>
> *Therapist: Right.*
>
> *Father: ...he's a changed kid now that he has stopped playing rugby...*
>
> *Mother: He is.*

*Father: ... he's a changed, changed kid. And that he made that decision himself and what I learnt from coming here was that I must also listen to others' needs because I would always say, "So far, no further would I listen to you because you don't know, I know!" So I have had to take a step back and say, "But, listen Bill, hang on a moment, they do know." (p 181)*

Please also refer to Session 8 (p 160-79) for the whole family's evaluation of any therapeutic shifts and changes during the final family therapy session, as well as Session 9 (p180-201), the final parent guidance session, for Nina's and Bill's comments in relation to themselves, their own relationship as married partners, their family relations and the therapeutic resolution of Tom's presenting problems.

# Chapter 8

## Discursive Clinical Analysis: Dyadic Unit (Couple)

Ronel Smit (39 years old) and Peter Brown (48 years old) wished to be married but, unfortunately, unremitting interpersonal conflict threatened to destroy their three and a half year romantic involvement. Both had tried to improve the quality of their relationship but every constructive attempt had met with repeated failure; their relationship was steadily deteriorating and their future prospects as marriage partners seemed dismal. After the last of many breakups and subsequent reconciliation, Ronel had agreed to resume the relationship on condition that they attended couples therapy together. Although she ideally hoped that this would provide the necessary forum for the realization of their marriage plans, her primary motivation for initiating therapeutic intervention was to identify whether indeed she should persist in her attempts to improve matters or simply withdraw from the whole situation given that their relationship would never work - couples therapy was the final test:

> Ronel: *I think that we have been running at an absolute emotional loss. At times it has made me physically quite ill. We have had good times together...* (p. 563)
>
> Ronel: *I don't know, Mark, I think it comes from the fact of the pattern of the relationship has been the same kind of pattern over and over again and I think when something like that starts happening I, for one, said to Peter the last time when we got together, "We are going to do this with a counselor and if (own emphasis) it is not going to work with a counselor, then it is not meant to work!"* (p 573)

Peter had agreed to these conditions and Ronel had set up an appointment for couples therapy with me on an acquaintance's recommendation. The therapeutic outcome was successful in that Ronel was able to make and act upon a deliberate decision to leave the relationship. This agential act was possible given her gradual understanding through the therapeutic discourse that their respective needs as partners were incompatible with one another on too many levels; their basic discursive incompatibility would therefore necessarily require considerable effort from both partners in order to ensure the smooth operation of a potentially complex, reconstituted family scenario involving three children of eight, fourteen and nineteen years of age. Through the therapeutic process, Ronel was able to gain discursive perspective on her life circumstances in that she became acutely aware of the reasons for their basic incompatibility as long term married partners and parents to three children, as well as their respective reluctance to invest the required time and effort in working towards greater compatibility as married partners and parents. Furthermore, although I suggested investigating alternative social living arrangements to traditional marriage as heterosexual partners, Ronel

remained adamant that she wished to be married within the traditional discursive story-line. Peter, on the other hand, had been a somewhat unwilling therapy candidate from the beginning and had only agreed to couples therapy given Ronel's insistence. He did not seem to shift psychologically to any great extent through the therapeutic discourse although towards the close of therapy he had become more aware of his personal position in relation to any future marriage plans with Ronel or any other woman. That is, he realized as a divorced person with a child that he was located in a complex network of familial discourses; any reconstituted familial arrangement would demand a huge investment of both time and effort. This was a commitment he was hesitant to make given his preference for a more relaxed, less pressured sense of being within any romantic relationship with a female partner. It seemed that during the process of therapy, Peter was better able to identify and accept his discursive reality and limitations and make more deliberate agential decisions in this regard although he still remained ambivalently attached to Ronel in the hope of realizing some form of romantic social arrangement with Ronel. Unlike Ronel, Peter was prepared to consider alternative social arrangements to traditional marriage for their meaningful relating as a heterosexual couple - unfortunately this was yet another in a long list of principal areas of discursive incompatibility between the partners. Ronel therefore saw no alternative but to end the relationship decisively and pursue her own personal development in efforts to eventually realize her marriage plans with another, more mutually compatible partner in time to come. These considerations are discussed and indexed to the transcripts throughout the course of this chapter.

Please refer to the introductory discussion on the dyadic unit for further details on the couple's characteristics and history (see p 202-203). In addition, Ronel felt more comfortable expressing herself in writing and had given me two recent letters to read during her private intake session; please refer to these for first hand commentary on the nature of the couple's difficulties as understood by Ronel (see p 203-210). Finally, Chapter 6 outlines the diagnostic (research) procedure adopted with the couple and provides further background and orientation for the reader on their situation. This discursive clinical formulation chapter follows the format of the preceding one; that is, diagnostic formulation (DSM IV; discursive clinical formulation); and therapeutic positioning discussion in relation to the different schools of thought outlined in Chapter 1.

## DIAGNOSTIC FORMULATION

### DSM IV classification

Formal diagnosis was never discussed with the couple since it did not seem useful for the attainment of their therapeutic goals; emphasizing psychopathology for either partner at an individual level would have jeopardized my efforts to improve their *relationship* - therapeutic balancing strategies

(systems-theoretical technique - Chapter 7) would have been compromised. A clinical psychology position (DSM IV) on their difficulties at both the dyadic and individual level might read as follows therefore:

***Peter:***

| | |
|---|---|
| AXIS I | Partner Relational Problem (Code: V61.10) |
| | Vascular Dementia, Mild with Depressive Features (290,43) |
| AXIS II | No diagnosis, narcissistic features (V71.09) |
| | Frequent use of denial |
| AXIS III | Hemorrhage, intra-cerebral, non-traumatic (431) |
| | In full remission |
| AXIS IV | Problems with primary support group (divorce) |
| AXIS V | GAF = 65 (Intake) |

***Ronel:***

| | |
|---|---|
| AXIS I | Partner Relational Problem (Code: V61.10) |
| | Depressive Disorder NOS (311) |
| AXIS II | No diagnosis (V71.09) |
| AXIS III | Neoplasm, malignant, breast (174.9) |
| | In full remission |
| AXIS IV | Problems with primary support group (divorce) |
| AXIS V | GAF = 65 (Intake) |

I attempted to integrate all the information gathered over the intervention process into this DSM IV classification while maintaining a fair distribution of 'psychopathology' between the two parties. For example, both partners were assigned identical Axis I diagnostic labels (primary diagnoses - Partner Relational Problem) as well as on Axis IV (psychosocial and environmental problems) since they both experienced adjustment problems in relation to their ex-spouses as divorcees, and with Peter's son (Jeremy, 8 years old). Furthermore, both also received the same Global Assessment of Functioning (GAF) score on Axis V based on the clinical opinion of one of the two individual level co-therapists (GAF = 70) and myself (GAF = 60); I took an average of the two scores (see Session 1 (p 211-237) for co-therapists' discussion on diagnosis). I used my diagnostic contribution to 'balance' the partners scores in order to maintain my position as *couples* therapist at the dyadic level. This was possible since the GAF score criteria are sufficiently flexible to accommodate different positions on adaptive functioning; by using a team for diagnostic perspective, fairness and balance could be created within the parameters (limitations) of this diagnostic classification scale. These notions also

accommodated the couple's position as this diagnostic classification reflects my therapeutic efforts at creating an harmonious relationship; this was ideally what the couple wished to achieve in couples therapy, and even distribution of blame ('pathologizing') was critical for the achievement of these goals.

Although both partners qualified for Axis III diagnosis (Ronel had been successfully treated for breast cancer during the previous year (see p 528)), Peter was particularly vulnerable to possible 'pathologizing' due to his positioning within the psychiatric story-line: he had suffered a severe stress induced brain hemorrhage which occurred approximately one year prior to the initiation of their intimate involvement. This had left Peter's cognitive functioning mildly impaired; the physiological nature of his difficulties could have become the overriding focus of clinical attention. I however deliberately submerged the psychiatric story-line in this particular case given that the couple had been fully immersed (frozen) into this discursive position (Peter had been seriously ill and Ronel had chosen to nurse him from the outset of their relationship (see p 483)).

I therefore attempted to de-emphasize 'psychopathology' as far as possible at a public-dyadic level, while reserving my clinical opinion for my own private-individual level consideration during the course of therapy with the couple. Further motivation for this therapeutic positioning choice was indicated by their lack of progress towards their relationship goals while employing the 'ill-healthy'; 'patient-doctor' position; that is, both partners had sought assistance from Peter's neurologist in an attempt to address their relationship difficulties from a medical perspective - this had not worked as their request for couples psychotherapy clearly testified (see Ronel's letters to the neurologist, p 203-210) . I therefore needed to position myself within some alternative story-line in order to facilitate their stated goals while still maintaining congruence with my mandate as a clinician. My therapeutic positioning appeared to be successful since towards the close of therapy, Ronel wrote the following in a faxed letter sent directly to me:

> Ronel: *In your wisdom you would probably spot the problem immediately.*
> (p 524)

The DSM IV criteria for Partner Relational Problem reads as follows:

> "This category should be used when the focus of clinical attention is a pattern of interaction between spouses or partners characterized by negative communication (e.g., criticisms), distorted communication (e.g., unrealistic expectations), or noncommunication (e.g., withdrawal) that is associated with clinically significant impairment in individual or family functioning or the development of symptoms in one or both partners." (DSM IV, 1999, p. 684)

That is, Peter continually complained about Ronel's 'criticism' of his failings (see p 353 and 390) and intermittent withdrawal from the relationship (see p 382-385), while Ronel complained bitterly about Peter's 'distorted communication' and 'noncommunication'; that is, his memory difficulties (eg, not remembering an important letter given to him by Ronel about their relationship difficulties (see p 534)), fatigue (eg, being too tired in the early evening to speak about important relationship issues (see p 563)), concentration and language comprehension problems (eg, losing the thread of social conversation (see p 347-350)), his attendant denial of any neurological deficit under these circumstances (see p 350 and p 563) and his tendency to avoid discussing emotionally difficult interpersonal issues (see p 517).

Their communication difficulties resulted in both partners developing depressive symptoms; that is, Ronel experienced low mood (Depressive Disorder NOS (see p 564)) while Peter's depressive symptoms (Vascular Dementia, Mild with Depressive Features) deepened with each breakup (Peter's individual-private level co-therapist diagnosed the presence of Dysthymic Disorder NOS (see p 212) while Peter also informed me that his neurologist had prescribed anti-depressant medication for him after their last breakup (private intake session, see p 202)) - for example:

> Ronel: *And also the intimate communication. Ja, that is helluva important to me. I don't want to just chat to you about how's the garden and how's the this. And with him I always felt a block in the communication when it went that way. Um, he probably doesn't feel at ease talking about things - or things that are hurting; "This has hurt me." I can't communicate that with Peter. If I can't communicate that, it stays inside. It makes me ill eventually and it doesn't work...* (p 576)
>
> Ronel's letter on Peter: *At times he is very emtionally fragile e.g. someone would ask how is Jeremy (Peter's 8 year old son) ...his answer would be o thank you for asking he is very well and the expression on his face would be close to tears ...Princess Di's death he mourned for weeks, bought a poster of her hanging in the lounge ...if this conversation comes up he is fragile about it.* (precisely as written) (p 208)

It is however important to point out that Ronel's depressive symptoms were also tied in with her recent recovery from breast cancer (see p 528) and her sense of loss and guilt at destroying her relationship with her ex-husband (Jan, the adoptive father of her two daughters from a previous husband who had died tragically when Ronel was still in her twenties (see p 202-203)) and divorced him to get married to Peter (see p 573-574). She had developed a staunchly independent way of positioning herself within the discourses comprising her world yet she simultaneously sought to be

positioned as a 'dependent-woman-on-a-man' within the social identity story-lines of 'marriage' provided by her Afrikaans-speaking cultural environment (see p 225-226 and 310-317). From within the psychiatric position, these conflicting story-lines may be understood to have predisposed her towards depressive moral assessments (feelings of helplessness and loss of control; that is, loss of a sense of personal agency) of her world since she was positioned in contradiction; as with Peter, her depressive symptoms were not exclusively centered around their relationship difficulties but deepened with every break up.

While both partners received no Axis II diagnosis since neither of them met full DSM IV criteria for any specific personality disorder, Peter did exhibit some very rigid coping styles in his interactions with other people that suggested clinical features associated with narcissistic personality disorder. That is, Ronel, Lisa (Peter's individual-private level co-therapist) and myself all independently experienced Peter's interpersonal interaction style as being oppositional and uncooperative (criterion 5), self-centered and lacking in empathy (criterion 7) and tended to be interpersonally exploitative (criterion 6) (see Ronel's comments, p 575-576; and Lisa's comments, p 213-214). These problems seemed to interfere in his ability to maintain harmonious, long term intimate relationships with women; that is, Peter had chosen to remain single until he married in his mid thirties and prior to this he had never cohabited with a partner although he had had a 6 year relationship with a steady girlfriend. Further, his marriage had been unstable before eventually ending in divorce with ongoing conflict between the ex-spouses (see Session 11 & 12, p 404-448 for details on Peter's problematic relationship with his ex-wife). The chronic nature of these interpersonal problems and the suggestion of early adulthood onset is possible indication of narcissistic personality disorder features if Peter's interpersonal positioning activity is positioned within psychiatric discourse. Indeed, his stress induced stroke provides further evidence for this hypothesis if the following argument is considered; that is, the brain hemorrhage may have been precipitated by this coping style since by being self-centered and uncooperative in his interpersonal positioning activity, he would necessarily be in a constant state of vigilance and emotional arousal, it would seem to me, in order to maintain control in interpersonal relationships. While this positioning activity within the story-lines of personal gain and achievement may have served Peter well as a self made businessman (he was worth millions (see p 202-203, 205-207 and 287-288)), it didn't seem to have been as useful in promoting the workability of intimate, long term, live-in relationships such as marriage. His stroke also occurred a few months before his divorce with his ex-wife. This seems to suggest that the emotional distress generated by his interpersonal problems with his ex-wife (he was divorced at the time of meeting Ronel) conjoined with work related stress (identified by Peter as the cause of his stroke (see p 219)) may have been mutual contributions, along with possible predisposing physiological (constitutional) vulnerability, to the precipitation of his neurological illness and his resulting functioning impairment. There is further

support for this argument from his relative denial of his impaired neurological status (p560) and his reluctance to participate in therapeutic efforts such as speech or occupational therapy (see p 217-218).

Although Ronel did not meet any DSM IV criteria for personality disorders, her relationship difficulties indeed seemed broader than her involvement with Peter; in effect, she had chosen to walk out of a reasonable marriage and in so doing had alienated both herself and her children from their father albeit to marry Peter. She had been very circumspect in articulating all these facts clearly during the intake sessions and indeed had implied that her ex-husband's 'womanizing' had been one of the causes of her leaving the marriage for Peter (see p 202-203 and p 231-234). Only later on did she make it clear that she had begun the affair with Peter while her marriage had still been intact and her ex-husband faithful (see p 453, 462-463 and 582) and admitted her guilt and moral irresponsibility. Unlike Peter who expressed few self-recriminations and very limited self-awareness as to his own contributions to his ongoing relationship problems (see p 213), or his pre-morbid stress levels for that matter, Ronel fully acknowledged and felt deep remorse that her whimsicality had led to destructive consequences - she accepted responsibility for her error of judgement and chose to repair matters where possible (see p 581-583, 589-590 and 592).

Through the therapeutic process Ronel gradually attained further insight into the underlying, unconscious (implicit) story-lines which had contributed towards her foolish decision to leave her ex-husband for Peter; she chose to continue the reconstruction process alone in individual therapy after deciding finally to terminate any marriage plans with Peter given the outcome of the process she had undertaken (see p 589-592) in order to clarify matters for them as a couple. It seemed to me, therefore, that Ronel's difficulties involved an error of judgement (choice) given contradictory and complex story-lines comprising her personal history as a woman and the situated discourses in which she was positioned in her life both generally and together with Peter. On the other hand, Peter's interpersonal difficulties seemed more chronic (time) and persistent and occurred in a range of social contexts which suggested the presence of more enduring personality features; that is, historically evolved, inflexible and rigid story-lines and positions at the individual-private level (personal identity) which interfered with his ability to function optimally at the collective-public level in interpersonal relationships such as marriage (social identity) but which had made him a highly successful entrepreneur (social identity) given the different discursive practice requirements of the two social activity contexts.

**Discursive clinical formulation**

From a discursive clinical position, Peter and Ronel's relationship difficulties might be understood as having emerged as a function of different forms of discursive incongruity; that is, 1] between their social identity aspirations and their actual relationship; 2] their respective positions as individuals in relation to each other; 3] and within the personal identity of each partner as individual. These discursive structural anomalies seemed to precipitate and maintain their negative emotional assessment of their relationship; that is:

firstly, the couple wished to relocate their social identity at the public-collective level; both were divorcees and wanted to re-position themselves as a 'married couple' within their culture specific story-lines sanctioning heterosexual bonding. However, at the individual-private level, their respective personal identities comprising historically evolving story-lines, positions and attendant emotional investments in connection with long term partnerships, threatened to eclipse their plans given the relative incongruity of their social and personal identity aspirations; that is, their social identity aspirations *necessarily* required a level of mutuality and sharing as intimate partners as each understood this (see p 576 (Ronel), p 568 (Peter)). However, these expectations were contradicted in their actual communication with each other (discursive positioning sequences). Both partners positioned the Other as the cause for their inability to attain a shared social identity as marriage partners and their resulting emotional pain (see p 576 (Ronel), p 568 (Peter)).

Secondly, discursive disjunction also involved mutually contradictory story-lines and/or positions at the individual private level given the same speech-acts at the public-dyadic level. For example, Ronel had understood that she was assisting Peter's recovery by pointing out his errors (eg, his memory problems while driving) since any criticism was meant to show her care and concern as an intimate female partner for her man. On the other hand, Peter resented a potential partner who persistently pointed out his failings (see p 391-392):

> Peter: *Before you were very critical on me. The fact that I couldn't concentrate, and my communication was bad, all those kind of things...*
>
> Ronel: *I felt that I helped you ...*
>
> Peter: *Ja, well, whatever ...* (p 388-389)

It seems that their positioning activity from their respective positions at the private-individual level (Self) was unconscious (opaque) to the Other; this caused severe interpersonal conflict which was in contradiction with each of their expectations (story-lines and positions for anticipating the future) about harmonious marital relations and communication; that is, their aspired social identity. Their negative emotional assessments (eg, depressive feelings) of these circumstances might be understood as indexing the disjunction between their *anticipated* positioning within story-lines for each partner at

the private-individual level regarding their shared social identity, and their *actual* relationship as experienced by each partner - the two levels of discursive disjunction mutually interacted in complex ways.

Thirdly, the discursive disjunction complexity involved contradictory story-lines at the individual-private level for each partner as well which interacted complexly with the other two discursive levels discussed above. For example, Peter enjoyed being intimate with women who were strong and demanding yet also resented it while he would simultaneously never back down during confrontation episodes:

> Peter: *Some people that I have always had long relations with have been quite demanding people. I don't want a soppy thing who says, "Yes, sir!" I don't like that...*
>
> Therapist: *Okay.*
>
> Peter: *It gets boring for me...*
>
> Ronel: *And his ex (wife) was quite a strong woman.* ***Sy ma het hom bederf en sy pa is baie domineerend.*** *(His mother indulged him a lot and his father was very dominating.)*
>
> Peter: *I don't want a woman who is soppy; when I say, "Jump!" she jumps.* (p 390)
>
> Peter: *In general. She (Ronel) is quite a demanding person, you know. This and this and this and this. Some of those issues. She is quite ... I like that. I don't say I don't like that but there comes a point in time ... I like a formed, firm person but there comes a point in time when you mustn't be too dominating, because then it builds up. Then I get* ***bedonered*** *(angry) ...* (p 389-390)
>
> (edited)
>
> Peter: *I am also quite a demanding person. I think we both are and that is why sometimes things build up....* (p 393)

Peter's contradictory positioning of women within this story-line clearly made it difficult to fulfill his expectations and would almost inevitably lead to communication breakdown in intimate relationships given the double-bind (systems-theoretical construct).

Similarly, Ronel positioned men within contradictory story-lines since, on the one hand, she wanted to be independent, autonomous and in control yet she also wanted to be dependent, protected and cared for:

> Ronel: *Think of it in the matter that I gave up my business life to accommodate a different life style. And I think what I did is that I put him (ex-husband) up on such a big pedestal and I really worked for* ***his*** *(own emphasis) life. When he was up there and out and about and all over the place, he neglected me a bit. And I don't think I could handle that ... (p 583)*

Ronel: *...and that is maybe why I play this incredibly independent scenario here. Maybe that is why. If you ...***jy kan my hele getroude lewe kyk. As iemand op die ouderdom van 19 jaar hard gewerk het** *...(you can consider my entire married life. If someone has worked hard since the age of 19 ...) she is going to be like that. Unless she got married to a man whom she knew that he was leading on the financial issues. Then she could relax. She could relax, she knew he knew what he was doing, she could be fine.* (p 312)

Ronel: *You know, I wouldn't mind if I could now be truly laid back and relaxed and have somebody else survive in that little part for me. I would be very happy.* (p 311)

These contradictory positions within the traditional marriage story-line seemed to have been played out in her relationship with her ex-husband and Peter; that is, she left her ex-husband because she felt she was in his shadow and felt neglected while he was busy developing his career (see p 582-584). At this time she met Peter who was extremely weak and vulnerable after his divorce and stroke. By nursing a very ill but powerful man she could resume a position of control yet she longed to settle down and become dependent once again with Peter (see p 528). These contradictory story-lines were continually played out throughout the relationship since Ronel would withdraw from Peter as a way of restoring control in the relationship and retrieve her independence (see p 527), yet she would become very fragile and dependent after a while and return to his side hoping that their relationship would improve (see p 564).

Peter found her contradictory positioning within the two story-lines confusing and upsetting which only made him more uncooperative and self-centered (see p 537-538).
These discursive incongruities lead to repeated cycles of ongoing conflict which became progressively worse and worse until another breakup occurred. Each time these cycles were repeated their mutual trust was further compromised making it ever more difficult for Ronel and Peter to achieve their social identity goal as cohabiting married partners with a reconstituted family of three children between 8 to 19 years of age (see p 572-575).

Given the couples mandate and this discursive clinical formulation, I therefore understood my therapeutic role to involve assisting the couple, firstly, to gain insight into these discursive structural anomalies of which neither was fully aware, and secondly, to mediate necessary skills in order to close the myriad discursive gaps which maintained their discontent, and finally, to assist both partners in deciding whether they should 1] persist in working on their relationship in order to attain their marriage goals, or 2] re-structure their social identity goals in order to accommodate their actual

relationship, or 3] whether to abandon any intimate alliance due to their lack of congruence as intimate partners. We will consider now the therapeutic positioning process which I facilitated in order to fulfill these therapeutic goals.

## THERAPEUTIC POSITIONING

### Psychiatric

I deliberately chose to submerge the psychiatric story-line given the couple's foregrounding of matters medical for reasons discussed earlier in this chapter. However, I did use a medical story-line during therapeutic positioning in their first couples therapy session in an effort to 'perturb' or 'unfreeze' them from their entrenched positions so to begin the discursive re-construction process. That is, Peter's son Jeremy had been their main focus of concern given that many of their fracases centered around their divergent story-lines on how Jeremy fitted in with their relationship together as a couple (see p 205). I therefore used a sustained medical metaphor throughout this first session in order to persuade each partner of my modus operandi as a mental health professional which gave me the initial credibility for their seeking my assistance; that is, I used their medical story-lines (vehicle) to shift their interpersonal discursive positioning towards alternative narratives (tenor) through metaphor. Specifically,

> Therapist: *I think that we must understand Jeremy not as the problem in the relationship but more as the symptom of the problem.*
>
> Ronel: *I agree with that 100%*
>
> Peter: *(Doesn't respond)*
>
> Therapist: *It is where it is all coming out but it is not the problem. You know if you have a headache you might actually have a problem with, say, your kidneys or your liver or something. It doesn't mean now that your head is the problem.* (p 252)
>
> Therapist: *So I am not going to be able to give you any quick answers about that (their conflict re Jeremy) in order to be able to solve this one. It has been going on for three years and I am saying that we at least need the two and a half months, or so, that we are putting aside now to get going to solve it properly. It is like trying to mend a fractured leg with a few bandages. It is not going to work. We need to do it properly. We need to, kind of, administer anaesthetic, to set the leg, plaster it properly and give it time to heal and what not.* (p 250)

Given the psychiatric reading of Peter's interpersonal positioning activity generally and the rigid story-lines he held in relation to his responsibilities as a father specifically (see p 226-230 and p 317-319), I believed that it was therapeutically useful to submerge the couple's parenting story-lines until

later in the therapeutic process so that less contentious issues between the partners could be resolved first. This would, firstly, allow for the development of conflict resolution skills which could be effectively used when attempting to resolve their more challenging problems and, secondly, by achieving early interpersonal conflict resolution successes, I believed that the couple's perceived sense of helplessness and loss of control (depressive symptoms), given their relative lack of personal agency and failed efforts to achieve their social identity goals, would improve; that is, as the partners began to feel more optimistic about their relationship, I hoped that this would provide the necessary impetus for them to begin initiating a positive therapeutic spiral towards self reported health and psychological wellbeing. My therapeutic positioning efforts were supported by Ronel's decision (during individual therapy with her co-therapist) to withdraw from social situations where Peter and Jeremy were together (see p 230 and 249-250) in order to avoid conflict; I supported her decision as a temporary resolution (see p 250) since it suited my overarching therapeutic positioning.

Finally, it was clear that a clinical psychology position may well have dictated my attempting to promote the couple's adjustment to Peter's neurological difficulties. For example, I might have helped Ronel understand Peter's limitations given his 'illness' and assisted her in becoming a more sensitive 'nurse'; simultaneously, I could have helped Peter in acknowledging his 'illness' and used therapeutic positioning sequences to persuade him into self confrontation by exposing his denial and his reality as a 'patient'. I certainly was within my rights as a clinician to do so and, indeed, some clinicians may argue that I was *obliged* to locate myself into this position given Peter's denial and Ronel's critical insensitivity and his neurological disease. I however chose to be guided by the overarching meta-principles of discursive clinical psychology by adopting the following therapeutic strategies:

- firstly, given that discursive clinical psychology acknowledges the patient's narratives as primary, I colluded with Peter's denial at times (see p 350-351) since this was the position that *Peter had chosen* within the psychiatric story-line.
- secondly, my position as clinician also needed to be acknowledged since I was one of the primary actors present within the moral order of the therapeutic context. However, as clinician, confrontation did not seem therapeutically useful for the attainment of the *couple's* mutual therapeutic goals. By highlighting Peter's difficulties against his will, it would only serve to maintain their relationship status quo where Ronel was the 'nurse' and Peter the 'reluctant patient' within the medical story-line; their discursive positionings would have become ever more cemented albeit more refined, to the potential exclusion of their roles (positions) as 'man and wife' in the marriage story-line given the conflation of the two story-lines. Moreover, the 'patient-nurse' positioning is full of implicit assumptions about the '*power* of the nurse over the patient' and clearly Peter found any 'one down' discursive positioning within the relationship extremely

threatening. It is very possible that he would simply have continued to refuse the positioning and rebelled in one or another way; their mutual social identity goal (marriage) would probably have become ever more unreachable while their 'nurse-patient' positions became more deeply entrenched - Peter would be 'the difficult patient' and Ronel the 'long suffering nurse'.

- thirdly, if this approach had been pursued, it necessarily excluded other relationship conflicts since Peter's illness and their implicit power relations one to another would always overshadow other discursive practices that needed addressing.
- finally, clinically speaking there seemed sufficient evidence that Peter's patient role could have been precipitated by psychogenic factors (discourse) while Ronel's voluntary positioning in the nursing role seemed motivated by her conflicts at the private-individual level (see earlier comments in this chapter); indeed the deeper layers of their discursive positioning in the world seemed to have given form to their 'patient-nurse' positions and not conversely - *discourse* structured physiology. These meta-theoretical considerations indeed augmented my role as clinician and provided useful analytical (discursive) tools for executing psychotherapy and in assisting Ronel and Peter in reaching their therapeutic goals.

**Psychoanalytic**

In order to explicate how the implicit (unconscious) discursive practices *throughout* their social history had contributed towards constructing the discursive practices and subject matter comprising their 'actual' relationship as a couple, an historical review of their respective life experiences was conducted during the course of the therapeutic process. For example, we explored Peter's discursive constructs around 'criticism'. I therefore assisted Peter in gaining insight into the historical roots of his positioning within 'critical discourses' in order to explicate these unconscious discursive processes and demonstrate to both partners how Peter was simultaneously positioning Ronel and choosing to be positioned by her in terms of discursive practices that were not necessarily useful for the attainment of their goals as a couple; that is, to reveal how his discursive history (unconscious - personal identity) was preventing their attainment of harmonious communication with each other (expected social identity) (see p 320-328):

> *Peter: Ja, I wouldn't say ... ja, I wouldn't say all parents are like that. Not at all. But I just know my parents are quite demanding and quite critical on many issues as opposed to being level headed, they are looking for the bad, accepting the bad without communication skills as to how to conduct the orchestra ... on that basis.* (p 321)
>
> *Therapist: Okay, so was that one way of dealing with criticism? You would withdraw?*
> *Peter: Ja ...*

*Therapist: Because you couldn't please them (Peter's parents) anyway, so to hell with it, kind of thing...*

*Peter: Ja, a bit like that ...*

*Therapist: Ja.*

*Peter: ...You say, "Don't be so bloody critical. Leave me alone." And it builds up over time.*

*Therapist: Sure, and then you would blow sometimes?*

*Peter: Ja...*

*Ronel: In a very bad manner. Blow. (Smiles)*

*Therapist: Meaning? Meaning what?*

*Peter: I can get extremely out of hand.* (p 322)

*Ronel: (Laughs)* ***Nee. Hy kan terrible tantrums gooi*** *(No. He can throw terrible tantrums) that will make you feel - no matter how happy, healthy you are - this man can make you feel like that (keeps finger and thumb one inch apart to indicate 'small'). He will do it in public. He doesn't care where it is. Wherever in public ...If Peter gets to that stage it doesn't matter to him. It is rude and he doesn't understand that!* (p 323)

Ideally, Ronel wanted a partner who showed caring socially and was dignified in his conduct; she found Peter's social ineptitude embarrassing and indicative of impropriety (see p 351-358) . Peter, on the other hand, longed for a conflict free relationship where he could just relax socially and have fun with a partner without critical judgement of his shortcomings (see p 563).

We also explored Ronel's social history in connection with her constructs around 'independence' because like Peter, she unwittingly (unconscious, unaware) actively positioned both Peter (e.g., he felt emotionally blocked out, unwanted and not trusted when she didn't discuss financial matters with him) and herself in contradiction through her internalized story-lines pertaining to her independence (autonomy) as a woman (e.g., through withdrawal tactics) given her aspirations in becoming a 'dependent wife' which involved locating herself into the obverse position (dependence) within the traditional marriage story-line: for example

*Therapist: But the moment it is about Ronel's business then* ***bly maar uit*** *(just stay out)! (Claps hands together and laughs)*

*Peter: Ja. Ja.*

*Ronel: Mark, I think it was because I was very young and started life very difficultly (as spoken) and I think when I was ...*

*Therapist: How old were you then?*

*Ronel: I was 19...*

*Therapist: You were 19.*

*Ronel: ...when I started my dress shop, so I have worked very hard.*

*Therapist: Okay, where was this?*

*Ronel: It was in the (mentions predominately Afrikaans speaking middle class area)*

*Therapist: Okay*

*Ronel: As I grew up as a child, during my childhood, first of all I was brought up being very independent. My mom's like that. My father passed away when I was 13 years old ...*

*Therapist: Okay.*

*Ronel: ... so we lived in this kind of ... this is the way we lived. Nobody looked after you. You have got to look after yourself.*

*Therapist: Yes, yes.*

*Ronel: I think that cost a lot and then what happened is that when my husband passed away I was 28 and I was left with two little ones, and I wasn't left with a world of money and everything, as I said to Peter the other day, was on my name, and I think there I had difficult times, you know. And even in the second marriage I didn't get married to a guy whom I could look up to financially. I was still the one who had to make the money. So maybe that is why (Ronel blocked Peter out about her personal financial dealings).* (p 305)

Ideally Peter wanted a marriage partner who would share financial matters with him and where there would be a mutual financial dependency and involvement (see p 300-304) and so did Ronel given her traditionalist story-lines comprising her discursive world:

*Ronel: ...but if it (financial dependency on a man) happens like that I would love it because I think I deserve it for a change.* (see p 312)

Through this socio-historical analysis, both partners therefore became progressively more aware of how and why their actual relationship was not always congruent with their expectations; once conscious and aware of these implicit structural anomalies within their personal identity discourses and the implications for their relationship communication, they could each begin to make clear, deliberate choices that would promote the effective attainment of their therapeutic goals.

As the therapeutic positioning procedure progressed over time, however, it became apparent from my position as psychotherapist that repairing the identified discursive disjunction levels to both partners' satisfaction would require considerably more work than the couple were prepared to devote to this restructuring task (see p 563). During Session 17 (beginning p 524) it became clear that the cycle of their 'actual' discursive interaction was being repeated (transferred, 'transference') into the therapeutic context; that is, Peter was generally unavailable to make more permanent marriage plans

and would not follow through on therapy homework assignments (systems-theoretical technique)(see p 526-530); Ronel became frustrated and reclaimed her autonomy by walking out of the relationship (see p 528 and p 524 (missed session)); she wrote Peter angry, critical, demanding letters (see p526-528); she also sent me a letter (see p524-525) as she had previously done with Peter's neurologist (see p 203-210); Peter continued to express bewilderment and exasperation at her behaviour (e.g., while waiting for Ronel at the missed couples session (p 524)) and, in turn, became more uncooperative (see p 529-531), and so on. Given the therapeutic moment (in this case 'transference' to the clinical context (see Chapter 7)), I decided to confront them on this discursive cycle intending thereby to break (transform) the cycle so that the two partners could be free to restructure their discursive interaction in some alternative manner which might yield greater self reported satisfaction.

I chose to do this by presenting their fundamental personal identity conflicts in context of their public-dyadic discursive interaction with one another; that is, based on the discursive analysis (diagnosis) conducted throughout of the therapeutic process (see Chapter 6), it seemed that the three identified discursive disjunction levels could be indexed by fundamental structural story-lines at the private-individual level for each partner as these related to the dyadic-public level (see the red area Q-Items in the Q-Method diagnostic exercise, p 273-275). Specifically, Ronel's contradictory self-location into the 'independent-dependent' position within the marriage story-line, interacted complexly with Peter's contradictory self-location since he simultaneously embraced and opposed critical, demanding and controlling women within the same marriage story-line. This resulted in recursive interpersonal discursive patterns (akin to psychoanalytic notions of 'repetition compulsion') at the level of their mutual, 'actual' social identity which again interacted complexly with their 'aspired' social identity story-lines; that is, where one partner moved forwards in terms of their mutual social identity goals, the other moved backwards. For example, before entering into therapy, Peter had asked Ronel to marry him but she had always refused (asserting her 'independence'). Now that Ronel had agreed to their marriage plans (relocating herself into the obverse position as 'dependent'), Peter was retreating given Ronel's poor relationship with his son, his different constructions regarding emotional intimacy (see p 580) and fears about marriage given his disastrous relationship with his ex-wife; while the more dependent and out of control Ronel felt, the more demanding she would become for intimacy, sharing, organization and clarity - in turn, Peter would become more uncooperative and opposing. Eventually this interaction cycle would result in Ronel reclaiming her independence and withdrawing from the relationship, which would be Peter's cue for attempting to win her back by being cooperative until she was ready once again to relinquish her independence which, of course, was his next cue for being uncooperative and withdrawing his commitment to the relationship given his reservations. If this clinical formulation were correct, this indicated the existence of a never ending, unsatisfactory discursive cycle between the partners; the

*whole* discursive structural base remained largely unconscious (semi-conscious) to the two partners. In my appointed role as therapist, I therefore confronted them with their unconscious reality both as separate individuals and as a couple (see p 531-538).

I did this by drawing two stick figures (Gestalt technique) on the white board in my consulting room and connected them together by drawing in a pole from the abdominal area of each figure. Using the same symbolic icons as on the Q-Method map (see p 273), I represented Ronel and Peter as the female and male partners, respectively. By using this 'connecting pole' metaphor (a systems-theoretical 'joining' strategy), it was possible to link their personal identity conflicts together with their dyadic interaction as a unit. By implication, the metaphor also revealed how their actual relationship contradicted their expected social identity as a married couple (see p 531-538).

I used both literal explanations integrated with psychoanalytic rhetoric in order to explain these story-lines. I explicitly used typical psychoanalytically-orientated 'word-notions' such as 'unconscious', 'child' (id), 'adult' (ego) and 'good/bad parent' (superego), 'parts of self' etc. which *metaphorically* indexed the complex discursive structural inconsistencies discussed above. This method also provided useful possibilities for reconstruction work; that is, throughout the intervention process, I proceeded *as if* the couple would get married as this was not only their ideal goal but through facilitating this process, it was possible for me to facilitate the couple's other therapeutic goals *simultaneously*. I therefore 'balanced' the explanation of the discursive clinical formulation by explaining their mutually dissatisfactory positions in terms of their each seeking from the other the 'good parent'; that is, Ronel needed Peter to be a protective and consistent 'father' for her 'inner child' while Peter needed Ronel to be a supportive but undemanding and overcritical 'mother' for his 'inner child'. By drawing on this family role rhetoric, I was able to apply Peter's rigid 'child-parent' story-line to their reconstruction efforts as spousal partners since by implication, Ronel also had an 'inner child' that should be treated with the care and concern that Peter treated his own son. On the other hand, Ronel needed to provide support rather than criticism for Peter's 'inner child' (see p 531-538).

Given the therapeutic moment, I also integrated this psychoanalytic rhetoric into re-authoring strategies (narrative therapy technique) around the notion of being 'adult' in order to 'perturb' them into further thought about notions of personal agency, freedom and responsibility in intimate personal relationships such as marriage (see p 538-545). This was useful since Ronel had already intimated that she considered their interaction to be somewhat 'childish' at times (see p 355).

Once confronted with their unconscious discursive processes, the couple and I discussed options for attaining more congruence between their experienced relationship and their therapeutic goals (see p 538-545). The following week (see Session 18, p 547) Ronel decided to follow through on one of the options, namely, to terminate the relationship although, unsurprisingly, Peter wished to continue with their relationship (see p 547-553). I supported her decision since it was her own and I believed that a suitable assessment process had already been facilitated. In the following (final) session (see Session 19, p 571), I therefore facilitated a ritual closing off where both partners explored what they had learned (cognitive-behavioral principles) from each other in order to raise their level of awareness (consciousness) still further in terms of their ultimate therapeutic goals as individuals; that is, how to make a satisfactory long term, intimate relationship work for their respective needs (see p 571-593)? In the last session Ronel decided that she needed some time alone in therapy to consolidate her sense of self and work through her personal identity issues in order to be a better partner for her next relationship. Peter decided that he ultimately wanted a more relaxed, carefree lifestyle unfettered by social responsibilities and emotional commitments given his personal affinities and complex familial circumstances. Needless to say, he changed his mind the next day (phone call to me) although Ronel seemed resolute in following through on her decision during the closing session (see p 591-593).

While many other interesting and significant psychoanalytically orientated therapeutic positioning strategies were used during the case study, space constraints do not allow further explanation. The interested reader is therefore further invited to consider the following sections in the transcripts as they refer to:

- discursive disjunction at the three different levels: p 312 (level 3), p 335-337 (level 3), p 426-427 (level 2), p 444 (level 2) and p 478-479 (level 2)
- rhetorical use of psychoanalytic discourse by Peter (p 490)
- Ronel's discursive slip ('lovable person', p 561)
- my use of counter-transference for diagnosis and reconstruction (p 509-511).

**Cognitive-behavioral**

Many of the techniques and principles discussed in Chapter 7 were also used with the couple since the interpersonal nature of both cases inevitably suggested similar therapeutic discursive practices, for example, mediating communication skills and problem solving techniques. However, in line with discursive clinical psychology meta-theory, it was necessary for me to apply these generic interpersonal skills as suited the idiosyncrasies of this particular case. I therefore taught the family 'I &You messages' along with 'double-wins' (see previous chapter for full details) to the partners but used alternative mediation techniques in this particular case. For example, Ronel spontaneously started using 'I-messages' (see p 328) early on in the therapeutic process and given the therapeutic

moment, I amplified this pronoun usage in order to teach both partners the necessary skills (see p 355-356 and 339-340). Similarly, I demonstrated the 'double-win' to the couple given the therapeutic moment (see p 337-338 and 307). In this manner, I could therefore reinforce and embellish existing discursive behavior for the attainment of their therapeutic goals. This was preferable to teaching entirely new or foreign skills; it was possible to boost the partners' perceived sense of helplessness and failure by showing how they might simply improve on the latent skills already in use.

At other times, I expressly *rehearsed* the skills with the couple, directing and correcting their application of the communication skills (see p 342-348). Rehearsal and repetition were needed throughout the process given their slow mastery of these ideas (see p 493-495). Therefore, in addition to using the same skills mediation methods adopted during the family intervention, I developed a moral dilemma exercise which required that the partners deliberately try to identify a 'double-win' solution. I constructed the moral dilemma (problem solving through metaphor) in such a manner that there was *one* correct answer (see p 521-522) (although I admitted that there may have been others that I had missed) which truly accommodated the notions of the double-win. The couple were not able to solve the dilemma which involved parenting issues and thereby highlighted the problematic performance level processes in their relationship (see p 515); by implication, the couple needed to carefully re-consider their future marriage plans given the complex problem solving required for harmonious interpersonal relationships within their envisaged reconstituted family (see p 517-523).

Problem solving skills in connection with a future reconstituted family were also mediated through direct examples from their day to day family problems. For example, the couple were receiving anonymous late night phone calls from an unknown source. Ronel was convinced that the caller was Peter's ex-wife (Milly) while Peter was unsure. After much discussion, I eventually suggested that they try and identify who the late night caller may be by tracing the calls electronically (see p 425, and p 405-431 for full context). The therapeutic benefits of these communication and problem solving skills and their rehearsal were further enhanced through ensuring that the couple spoke directly to each other during the sessions (see p 391 and 455).

Furthermore, as the therapeutic process progressed and it became ever clearer that the couple's actual relationship was indeed incommensurate with their social identity ideal, especially given that neither partner was prepared to put in all the necessary work in order to improve their relationship, I began generating problem solving options (see p 541-545) for restructuring their aspired social identity, so to accommodate and subsume the discursive practices already present within their relationship; that is

- continue with arrangements as they were albeit that they were miserable;

- formulate a formal relationship arrangement where the partners did not live together as man and wife but were both personally and socially committed to one another as a couple;
- terminate their relationship;
- I also made it abundantly clear that there may be many alternative options given further creative thought on the matter.

However, the problem solving process was cut short since the second option suited Peter (see p 587-588) but was not agreeable to Ronel, who wanted a traditional marriage arrangement or nothing at all (see p 554)! So positioned, Peter and I were forced to accept her decision.

To assist the couple in their process, it was also necessary to mediate certain abstract concepts so to promote their cognitive-behavioral skills development:

- I attempted to mediate a *future orientation* since the couple were often positioned in discursive fracas about past events and grievances which only served to maintain their unsatisfying status quo (see p 438-439 and 329).
- *Structure* was mediated given that their relative lack of structure as a couple seemed to contribute towards their reported misery (see p 202-209), for example, not keeping each other informed about their respective plans (see p 549-551) and following through on commitments (see p 574-575). The Q-Method map (see Chapter 6) and the attendant working through process (isomorphic with principles akin to the behaviorist technique of 'systematic desensitization') therefore functioned as a structured mirror of their relationship issues which facilitated systematic working through, item for item. The map usefully identified their most problematic issues (see p 273-274, 'red areas') which finally resulted in their splitting up as a couple as well as story-lines and positions that were keeping them together (see p 273-274, 'green areas' - e.g., Q-Item: 'sickness'). By setting homework tasks and creating behavioral *consequences* (see p 508-512) for the realization of this structured working through process, it was possible for the couple to become fully aware of their lack of structured interaction and simultaneously identify for themselves, through their own therapeutic *experience*, their need for structuration in order to achieve their social identity goals; once confronted with their own reality through this mirroring process, they were free to make informed choices (see p 574). To complement this structuration process, I also orientated them towards the goals of therapy and made it very clear that couples therapy under no circumstances focused exclusively on their remaining together as a couple; their personal choices and their commitment to the therapeutic process were their own responsibility; therapeutic success also included an informed, deliberate breakup as intimate partners (see p 238-239).
- I used my discursive interaction with the partners in the therapeutic context to *model* discursive practices which may promote their goals; for example, 'experimental working through'(see p 342

and 488), 'talking through issues' (see p 365 and p 379), 'negotiation and flexibility' (see p 429), and 'positive partner appraisal' (see p 333 and p 480).

Finally, Rational Emotive Behavior Therapy (REBT) principles were used throughout the therapeutic positioning process through story-line and positioning reformulation in order to facilitate the couple's goals For example, Ronel's need for clear boundaries with Peter's ex-wife albeit that he perceived no threat from her (p 425); Ronel cannot force Peter's family to accept her (p 480); choosing a more intimate social ritual for Ronel's introduction to Peter's parents (p 484); and demonstrating to both partners that Peter was still intact intellectually given his anticipation of my question (p 407-408).

**Humanistic**

Gestalt, client-centered and existential psychotherapeutic techniques and principles were also integrated with discursive psychology notions to promote my therapeutic positioning in terms of therapeutic goals:

*Gestalt*

Visual metaphors were used throughout the therapeutic positioning strategy in order to enhance the couples uptake of the mediated material. For example, in the 'two people yoked together by a pole' metaphor (see above), I rubbed the pole out after visually illustrating the ideas discussed, and began filling the resulting vacuum with words that indexed the positive discursive mechanisms previously identified as useful for their realization of the social identity goals (see p 538). Visual reinforcement of mediated ideas was also used in the iconography of the correlation agreement map presentation (see p 273 and Chapter 6).

Furthermore, structured, semi-structured (see p 479-480) and spontaneous (see p 464-465) role plays were used during couples therapy in order to assist the partners in developing new discursive practices and the first of these included the following:

- Structured role play

During Session 15 (see p 489), the couple completed a formal moral dilemma exercise which involved a structured role play outlining a fictitious story entitled 'The Family Business Crisis' (see Appendix, p). This was integrated together with the generic handout on 'I & You messages' and 'double-wins' (see Appendix, p) and presented to the couple as a skills development exercise. After debating the various issues through role play using the skills previously learned during therapy, they were to find a double-win solution to the problem.

The moral dilemma story was deliberately constructed around the couple's story-lines and positions pertaining to their most contentious problem, namely, their interaction difficulties with Peter's son, but in *disguised* form. I therefore created a fictitious moral dilemma story involving conflict between a 'mother', 'father' and a 'late adolescent daughter' within a 'family business' scenario rather than a 'mother', 'father' and 'young son' embroiled in parenting conflict in the 'home environment'. I also used positions and story-lines that I believed referred to the couple's interpersonal discursive themes and processes more generally, as had been revealed through the therapeutic process so far. For example, Peter's ambivalent allegiance to his parents' expectations of him (see p 329) was incorporated into the moral dilemma story through reference to sworn allegiance to parent figures about the nature of the 'family business', while Ronel's need for inclusion into Peter's extended family unit (see p 329) was also implied through this story-line. The cyclical nature of their interaction difficulties (see p 575) in disguised form were also introduced into the fiction where, for example, interpersonal silences lasting weeks after confrontation between the family members were typically interrupted by inquiry into one another's health. This seemed likely given Ronel and Peter's 'nurse' and 'patient' roles, respectively, within the medical story-line which had originally informed their bonding. Furthermore, through the role play, I was able to insert therapeutic material and ideas from clinical psychology discourse, such as the endless repetition of destructive interpersonal discursive patterns, and the resulting deterioration of emotional well being. These clinical psychology ideas were also repackaged as discursive metaphors that the couple could relate to, for example, progressive emotional deterioration was equated with 'running at an economic loss' in the family business. This facilitated the partners' uptake of these ideas as Ronel's spontaneous use of the 'running at an emotional loss' metaphor over the final sessions clearly demonstrated (e.g., see p 563-564). I also integrated two primary story-lines informing the couple's discursive world; that is, 'cooperative parenting' with 'business acumen and success' since parenting issues were a critical problem for the couple while both were highly competent business people. The moral dilemma story therefore conflated the discursive boundaries assumed between the two story-lines. This was done in order to encourage their utilization of well developed business related interpersonal skills for improving their parenting skills when working together as a couple. Although the partners were not able to resolve the dilemma since their habitual discursive practices informing 'How?' the couple interacted prevented resolution of a purely fictitious problem, their communication patterns were made abundantly clear to both partners (see p 513-523). In this way the 'performance' (as opposed to the 'competence') aspects of their discursive practices could be brought into relief and highlighted. This awareness building was reinforced by playing back a video recording of the role play to the couple during the next session (Session 16, p 508) where they were encouraged to analyse their own interaction and draw their own conclusions about their discursive interaction (see p 513-523).

The role play and video playback methodology worked well for the attainment of the projected therapeutic goals, in my opinion, and seemed especially useful in helping Ronel become aware of the structural difficulties within their interpersonal communication (see p 514-516). Although I cannot be sure, the procedure indeed worked so well in highlighting the underlying generative mechanisms supporting their relationship difficulties, that Ronel's insights resulted in decided perlocutionary level shifts within the relationship dynamics. This was indexed in the next session (see p 524) by the initiation of her final withdrawal from the relationship and her attendant letters to me and Peter. The letter to me closed with the following speech-acts which seemed to support this contention:

> *"Ronel: Damn Mark this letter sound so silly, but this is the way I have to write it to make myself clear. (as written)"* (p 525)

*Client-centered*

I used feeling and content reflections as well as reflective summaries in order to assist both analysis and clarification (see p 348) throughout the therapeutic process and also attempted to mediate a personal growth orientation for both parties (see p 380). At times either partner showed a significant lack of empathy for the other and I therefore also attempted to build up a 'feeling' vocabulary in order to facilitate their use of empathetic speech-acts. For example, I reflected Peter's position back to Ronel by providing a list of possible emotion words for describing what I understood to be Peter's inner emotional world (see p 347) at the private-individual level.

*Existential*

I used self-disclosure about my own relationship experiences extensively during this case study as a way of illustrating therapeutic ideas while also persuading the couple that the suggested ideas could indeed actually work; by implication, if these ideas had worked for me, then they might work for the couple (see p 365). Moreover, many of the ideas that I chose from the therapeutic literature had worked for me, and had therefore been tried and tested; I simply revealed to the couple central notions that I believed had been useful in forming and maintaining the good long term relationship that I currently experience. By revealing my personal identity in light of our collectively held assumptions around intimate adult relations (social identity), I was able to inform the couple that their aspired social identity was realizable if they chose to work towards this goal both as individuals and together as a couple (see p 481).

Mediating and highlighting ideas pertaining to personal choice (see p 315), responsibility (see p 426) and volitional freedom (see p 540) were also central to my therapeutic positioning strategy, especially given the partners' tendency to blame one another for their social identity failings as a couple. By highlighting the notions of 'choice' and 'growth', I was able to heighten the couple's awareness of

their personal agency as individuals and the impact that these concerns had on their experiences within their relationship and within themselves as they pursued their social identity ideal (see p 583-584).

**Systems-theoretical**

Strategic, structural, Milanese and eco-systemic therapy approaches provided essential techniques and principles for therapeutic positioning strategy during this dyadic unit intervention:

*Strategic*

While I could have utilized strategic intervention methods in an attempt to keep the couple together, I chose instead to facilitate a dual therapeutic process; that is, assisting the couple to develop both insight and skills that might improve their relationship if they so chose, while facilitating their decision making process as to their compatibility as a couple. If my primary focus had been on attempting to keep them together as a couple, firstly, I would not have honored the mandate provided by Ronel, who wished essentially to *clarify* her position with Peter, and, secondly, I would have been imposing a social identity formula upon the couple which may not necessarily have been an optimal social identity resolution for their respective personal identity needs or suppress to possible emergence of alternative social identity formulations. Any deliberate positioning of the couple within fixed social identity story-lines could indeed have resulted in further failure for the couple. I rather facilitated a reflective process for the couple to draw their own conclusions and refrained, on the whole, from any 'clever tricks' in order to keep them together. I however did use a few strategic paradoxes in order to 'perturb' the partners into further thought and promote the process of change generally; the *direction* of change, however, did not inform my use of strategic paradoxes - any perlocutionary shifts in their relationship were the partners' responsibility.

I also assisted the couple in gaining awareness of the recursive cybernetic feedback loops within their communication sequences that were maintaining their respective positions one to another (level 2 discursive disjunction); in this way, the couple became aware of the discursive mechanisms which existed within their actual social identity at the public-dyadic level - once conscious of these underlying generative mechanisms, it was their choice to shift these patterns towards their aspired social identity or create alternative solutions for themselves.

Both these aspects of strategic systemic intervention are well illustrated in the following example: I pointed out to the couple that the more Ronel held onto her independence, the more shutout and mistrustful Peter felt; in turn, he would become very interrogative and intrusive about her whereabouts, which destabilized their relationship still further; Ronel would feel still more insecure

and unsure about their compatibility as partners and, of course, she would hold on even more tightly to her independence while Peter became ever more mistrustful and interrogative, etceteras - this cycle was recursive and without end unless one or both of the partners chose to reposition themselves (see p 302-313). In order to facilitate change, I therefore suggested, paradoxically, that neither partner should shift and break the discursive cybernetic loops that bound the couple in their unhappy deadlock since they both felt safe in their respective positions (see p 308). I intensified this paradox still further by suggesting that Ronel should maintain her 'independent woman position' as it would be too difficult for her to give up her independence in light her 'hard-life-survivor' story-line and positioning (see p 313). Thereafter Ronel did indeed attempt to renegotiate her position with some measure of success, but retreated once again given her perception of Peter's lack of appropriate follow up (see Ronel's letters, p 524-528).

*Structural*

Both partners were positioned within complex familial story-lines as divorcees; their union as a married couple (spousal subsystem) inevitably involved their roles as parents in a reconstituted family (parental subsystem), on the one hand, and their relationships with ex-partners (ex-spousal subsystems),on the other. Both partners were emotionally enmeshed with their previous family sub-systems; Ronel with her ex-husband (see p 222), and Peter with his son (see p 226 and 203-210). Their respective enmeshments were interfering *significantly* in their relationship as a couple: Peter could not develop the requisite levels of trust for deeper commitment to their marriage plans, while Ronel remained skeptical about their union given their ongoing fracases over the management of Peter's son; it seemed that the more uncomfortable Ronel felt, the more she retreated into the relative safety of her relationship with her ex-husband, while Peter retained an intense emotional investment in his relationship with his son (see p 317).

I attempted to assist the couple in accessing their projected social identity within this complex discursive system by assisting them to strengthen the various subsystem boundaries using myriad techniques and principles from a variety of psychotherapeutic models (e.g., spousal subsystem (p 419-420); parental subsystem (p 555-562); ex-spousal subsystem (p 406-448)). In this manner I hoped to assist the couple in identifying primary discursive mechanisms within their surrounding familial world that would promote the development of appropriate levels of mutual trust for the attainment of their social identity goals.

This structural formulation comprised a meta-level analysis of the required therapeutic direction for the installation of useful discursive practices within the composite discursive system so to facilitate their broader goals as a couple; that is, to close the discursive disjunction between their anticipated,

aspired social identity and their experienced, actual relationship, with all the attendant restructuring possibilities - an harmonious reconstituted family was but one of many possibilities (see earlier in this chapter). In attempting to actualize this possibility, I could simultaneously address all the other therapeutic goals requested by the couple; by *not* achieving this ambitious task, the process functioned as a mirror for the couple through which they could make alternative, more realistic and appropriate choices at both the private-individual and public-dyadic levels (e.g., Peter repeatedly disregarded homework assignments (see p 490-491); this was central in persuading Ronel to finally leave the relationship (see p 563)).

It was therefore necessary to facilitate 'joining strategies' between the couple wherever possible so to strengthen a possible spousal subsystem, while simultaneously minimizing the intrusive influences of contending subsystems; in short, it was necessary to streamline the flow of discursive information both within and between the subsystem boundaries. This procedure can be understood as analogous to engineering optimal interaction between sequences of machine cogs. Similarly, my role as discursive engineer was augmented through the application of appropriate therapeutic tools (therapeutic positioning using diverse techniques and principles) from the broad range of psychotherapeutic disciplines discussed in this and other chapters.

*Milanese*

*Symbolic ritual* (see p 326-332), *reframe* (see p 357) and *extended metaphor* were used in my therapeutic positioning strategy. For example, symbolic ritual was used at the close of therapy once Ronel had decided that she no longer wished to pursue matters; that is, we scheduled a final session in order to reaffirm her decision since she had often tried unsuccessfully to leave the relationship, while also providing an opportunity for each partner to complete the therapeutic process: in this final session, each partner clarified their perspective on the therapeutic process and their relationship; they considered what they had learnt from each other through their being together, so that they might be more successful in their social identity aspirations with another, more personally congruent, partner (see p 571-593). Another example includes the use of extended metaphor since the couple were extremely competent business people and I therefore attempted to integrate their business-related discursive skills throughout the problem solving process. I therefore framed their social identity pursuits (marriage and a reconstituted family) as 'running-a-business'; this extended metaphor traversed the therapeutic process from start to finish (see p 241 and 445-8). For example, in my closing comments to Peter during their last session, I referred to the hard work that he had put into his business in the early days and compared this necessity to focused effort while working through

relationship problems, especially during the early phases of any relationship when partners are learning how to interact in mutually meaningful and agreeable ways with one another (see p 591). Once again Ronel's spontaneous use of the phrase, 'running at an emotional loss', demonstrates how this extended metaphor assisted her in developing the necessary insight and strength to follow through on her decision, *finally*. Reframe was used throughout the therapeutic positioning process in similar ways to those already discussed in Chapter 7 (see p 357).

*Eco-systemic*

Although I did not use eco-systemic techniques and principles in this case study as they are typically implemented, I did, however, implement the following discursive strategy: after the ritual introduction with Ronel and Peter's parents went so horribly wrong, it did indeed seem essential to consider an alternative social context for the realization of their mutual efforts. I therefore suggested that the couple create an appropriate introductory context for the ritual, for example, an intimate tea where they were both alone with Peter's parents (see p 478). Peter however chose not to follow through on this option which fueled Ronel's dissatisfaction and added to her final decision to abandon marriage plans (see p 527).

**Narrative**

Personal agency was once again at the centre of the therapeutic positioning strategy in this case study; all the other therapeutic positioning strategies attempted to mediate a sense of personal agency to the couple, both as partners and at the individual-private level. By raising their awareness of the implicit discursive mechanisms maintaining their relationship difficulties, both partners were in a position to make informed, conscious and deliberate decisions about their social identity ideal. Congruent with this meta-level goal, I also attempted to mediate necessary discursive tools (skills) in an effort to assist the partners in the implementation of their social identity needs and sharpen their sense of personal agency even further. It seems that the therapeutic positioning strategy was useful given that the process appeared to have empowered Ronel into performing a distinctly agential social act, one she had been unable to perform previous to entering therapy - both she and Peter were therefore free agents to continue the responsible pursuit of their respective social and personal identity goals as these pertained to intimate adult relationships.

I used narrative therapy re-authoring techniques and principles extensively throughout the therapeutic discourse. For example, the three of us discussed the meaning of personal agency in relation to the 'child, adult and parental parts of the psyche' (see p 538-541), and although this schema is a discursive fiction, it was useful as an explanatory and rhetorical metaphor for creating new perspectives on the partners' habitual story-lines and positioning concerning mutual dependency in

adult relationships; through this process, I was able to sharpen their awareness of their personal responsibility to act meaningfully as personal agents, and create greater personal wellbeing in their lives if they so choose. Consequently we also re-authored notions associated with 'love' and I injected the story-line of 'love-as-a-journey' into their discursive practices in order to assist their re-authoring of fixed story-lines and positions pertaining to love in intimate adult relationships (see p 366-370). Through this method I was able to reinforce their mutual awareness of the range of free choices available to them in their re-authoring endeavors; their discursive assumptions were the limits of their freedom.

**Therapeutic Deconstruction Analysis**

Together we deconstructed some of the *cultural* story-lines that informed relations between the sexes in order to both explicate any identifiable discursive assumptions that may have had bearing on the personal actions, while simultaneously 'perturbing' them into further thought by entertaining variations to their assumed relationship metaphors. For example, we considered power relations between men, women and children in the Afrikaans-speaking culture; that is, I pointed out that Ronel stuck rigidly to the autocratic story-lines applicable to 'child-parent' relations yet she did not subscribe to the similarly autocratic 'wife-husband' metaphors (see p 295). Furthermore, we deconstructed these familial and other social notions in terms of Afrikaans- and English-speaking cultural story-lines and positioning as these were understood by the couple (see p 285-296). This was necessary given Peter's discursive immersion in a predominantly English-speaking social context and his ambivalent identification with the Afrikaans-speaking culture, while Ronel was fundamentally Afrikaans (see p 285-296) - the couple made numerous references to their cultural differences throughout the therapeutic process (e.g., see p 205). I also 'perturbed' them into considering alternative relationship metaphors apart from traditional marriage as a possible social identity (see p 543-547) and 'unfroze' their positions still further by also pointing out the high prevalence of divorce amongst white South Africans (see p 541) and that therefore most white South Africans were in relationships that did not accord with the traditional marriage social identity.

## CONCLUSION

This case study was extremely complex and I therefore used a wide range of different therapeutic techniques and principles in my therapeutic positioning efforts. The reader will find numerous other therapeutic positioning strategies on close reading of the transcripts. However, given the limitations of this doctoral thesis, I have been forced to discuss only the most pertinent illustrative considerations for the purposes of academic argumentation.

At times I also felt that I might not be fully in touch with the couple's world since it seemed to me that there were suggestions of important submerged story-lines which were not considered. I tested this out briefly in the final session but my exploratory efforts were put into perspective by the partners themselves who simply corrected me where I had misconstrued their discursive reality (see p 577-581). All considered, I understand the therapeutic intervention to have been successful in reaching the partners' therapeutic goals.

**Chapter 9**

## Discursive Clinical Analysis: Individual Unit (Adult Male)

Mr Daniel Bruins (Dan, 45 years old) had been diagnosed as suffering from various psychiatric conditions since he was initially hospitalized and treated with addictive sedative medication (benzodiazepines) for 'homosexuality' at 16 years of age during the early 1970s (see p 706):

> *Dan: But the thing is this, I'm panicking a bit now because I might be sacked from my psychiatric career ...*
>
> *Therapist: Why?*
>
> *Dan: Because I'm defying a psychiatric diagnosis. I mean she (psychiatrist) will from next year write 'schizoaffective' because, you know, she says it's a bit of a cop out because (state mental hospital) ...I was sent back there because they're not too sure what's going on but they think its generalised anxiety, chronic depression and schizoaffective and whatever. I mean so ...*
>
> *Therapist: So let's just hear this. You are... (Rises and moves to the whiteboard and begins to write) ...*
>
> *Dan: Generalized anxiety disorder...*
>
> *Therapist: ... 'general anxiety disorder' (writes and repeats)...*
>
> *Dan: Chronic depression ...*
>
> *Therapist: ... 'chronic depression' ...*
>
> *Dan: And schizoaffective disorder ...*
>
> *Therapist: ... 'schizoaffective disorder'. Okay, and you've been a 'borderline personality' ...?*
>
> *Dan: Oh, yes, that's the big one, ja.* (p 877)

At the time of conducting this research case study (June 1999-February 2000), Dan had been living in a psychiatric half-way home for approximately one year, which was affiliated directly with the local state mental hospital. Dan had been on a government disability pension with his Axis II Borderline Personality Disorder psychiatric status for some ten years and also received a small monthly allowance from his mother and his deceased father's estate. He had chosen to live at the psychiatric half-way home given his limited budget and his preference for institutional settings over living alone (see p 631-2 and 701). The house parents (Mr and Mrs Enoch) provided both temporary and permanent basic subsistence for ten or so psychiatric patients at their residential home for a nominal fee (see p 623-632).

Previously Dan had lived together with his friend, Harry (see p 594-5, 757-781 and 757-781, for character and biographical details) for 25 years or so with intermittent separations for study (Dan had attempted and failed a number of university degree courses although he had achieved extremely well in foreign languages. He was also a capable classical musician and poet), hospitalization (Dan was intermittently hospitalized for life threatening overdosing (usually benzodiazepines) or suicide attempts requiring urgent intervention), spiritual enrichment (Harry periodically went into retreat etc.) or efforts at creating greater independence for Dan from Harry (see the interview with Harry for references to all of these aspects, Session 11, p 757).

Dan was primarily homosexual in orientation while Harry referred to himself as bisexual. They were only briefly sexually involved at the beginning of their friendship but had remained committed friends and flat mates. Dan had lived with Harry since his early twenties (see p 594). Harry was a Swiss trained Jungian analyst and journalist now 70 years of age, and had been in retirement for approximately three years; Dan had been forced to find alternative living arrangements and had finally ended up living in the Enochs' psychiatric half-way home (see p 632-4).

During the preceding 6 months, Dan's disability pension had been revoked and reinstated twice without any warning whatsoever given the general welfare policy changes in South Africa since the dismantling of the Apartheid regime in 1994 (see p 932, 936). Limited government funding was available for disability pensions of any sort due to the overwhelming need for reallocation of funds to the general population, for mainstream education, for example. Mental health related occupational incapacity was last in line, therefore, especially for personality disorders which were not considered sufficiently debilitating, as were psychotic disorders (e.g., schizoaffective disorder), for instance, to warrant disability funding (see p 915-6 and 932). The research procedure therefore correlated with a time of severe crisis for Dan with his tenuous disability grant, Harry's retirement and his reluctance to sustain and manage himself in independent work:

> *Therapist: ...At the end of the day, you sometimes just need bucks...*
>
> *Dan: What you're saying now makes a big impact...*
>
> *Therapist: Ja.*
>
> *Dan: ... because the **how** figures very much in this because if I am not motivated to do something, then I just fuckin' well won't do it! (looking defiant) ...*(p 672)

This chapter outlines the co-operative inquiry research procedure into discursive clinical psychology which Dan chose to undertake in an effort to improve his general psychological functioning and well being from a new and innovative perspective; after almost 30 years as a mental patient, Dan had found no therapeutic intervention sufficiently helpful in effecting his psychological health:

*Dan: ...but I have been through enough therapy to know very soon whether there is scope, you know...* (p 598)

Please also refer to Chapter 6 as well as the introductory comments to the individual unit transcripts (see p 594-595) for further details pertaining to this case study unit so to contextualize the ensuing discursive diagnostic and clinical formulation as well as the therapeutic positioning process adopted for this particular case study.

## DIAGNOSTIC FORMULATION

### DSM IV Classification

After having worked with Dan over the nine month research period, my independent DSM IV diagnosis might read as follows:

AXIS I: Sedative Dependence (Code: 304.10)
With Physiological Dependence
Early Partial Remission (at termination of research)
Sedative and Anxiolytic Abuse (305.40)
Generalized Anxiety Disorder (300.02)
Dysthymic Disorder (300.4)

AXIS II: Borderline Personality Disorder (301.83)

AXIS III: Hypertension, essential (401.9)

AXIS IV: Problems related to the social environment, occupational, housing and economic circumstances.

AXIS V: GAF= 12 (at intake)
GAF= 50 (at termination)

At one level, Dan's Axis I psychiatric symptoms (depression, anxiety) could be accounted for *exclusively* through dependency and abuse of the benzodiazepine family of sedative drugs (e.g., valium) as well as anxiolytic (anti-anxiety) drugs more generally, both of which inhibit physiological sensations associated with anxiety. During the course of the research process, Dan was officially diagnosed as being *dependent* on benzodiazepines; he experienced both withdrawal and tolerance symptoms and was referred by his state psychiatrist (Dr Brown), who had been dispensing the medication gratuitously for many years (see p 769-70) along with myriad other dispensing agents, e.g., general practitioners (GPs) (see p 758), to a drug rehabilitation center for treatment (see p 768 and p 940-4).

Originally, Dan had been prescribed benzodiazepine medication at 16 years of age (see p 706) after being diagnosed as suffering from 'homosexuality' according to the DSM II before homosexual orientation was removed from the list of officially recognized mental disorders in 1973 (Carson, Butcher & Mineka, 2000). He had also been treated with aversion therapy at a mental hospital for the same malady a few years later (see p 742-7). This first experience of benzodiazepine medication was followed by years of sedative abuse, and any medication with anxiolytic properties (e.g., certain headache tablets in large dosages), by persistently overdosing; each time his physical health was seriously at risk (e.g., renal failure) (see p 789). He however enjoyed the tranquil affective experiences induced by the medication (see p 789 and 958-9). In the case of the benzodiazepine abuse, Dan would take one or two tablets and then lose count and overdose, taking a whole month's prescription at once or over a few days. This behaviour often required emergency hospitalization and medical intervention to safeguard his life and was recurrent and persistent despite the life threatening nature of the substance abuse. Dan's various psychiatrists and other dispensing agents continued to prescribe benzodiazepine (see p 769, 789-790).

Many of Dan's other psychiatric symptoms (as I experienced them), such as anxiety, depression, cognitive anomalies and sleeping problems, could be ascribed directly to intoxication, withdrawal or the persisting side-effects of sedative and anxiolytic medication dependency and abuse. For example, the latest DSM IV (p 177) manual quotes dementia (cognitive processing problems), amnesic disorder (memory problems), mood disorders (depression, dysthymia), anxiety disorders (generalized anxiety), psychotic disorders (Dan and Harry said he hallucinated from time to time, although this was very infrequent) and sleep disorders (Dan suffered from periods of insomnia) as symptoms of sedative and anxiolytic intoxication or withdrawal; all these symptoms *resemble* Axis I disorders and can therefore be conflated with any primary Axis I diagnosis - Dan exhibited *all* of these symptoms during the research process (see p 660, 693 and 783 for mild dementia; p 638 and 770 for amnesia; p 638, 647-8 for depression; p 721 for aggression; p 637 and 707 for anxiety; p 831-2 and p 899 for psychotic features; and, p 707 for sleep disorders).

However beyond the possible effects of psychopharmacology, I did experience Dan as very anxious (stressed about) and depressed (persisting sense of helplessness, loss of control) about his life circumstances generally speaking during the research process. It seems however important to point out that his substance related problems *interfered directly* with his ability to acquire skills in order to promote his general life adjustment; this, in turn, served to maintain his stress levels and sense of helplessness about his life circumstances, which spurred him on to taking more medication (prescribed or otherwise) as means of coping - a complex synergy seemed to exist between the possible physiological effects of medication abuse and dependency, and the real circumstances of

Dan's life (see p 638, 928). In this sense, therefore, it appeared to me that substance related problems were at the epicenter of an Axis I diagnosis for Dan at the time of conducting the research.

On the other hand, when Dan was in his early twenties, the psychiatric community became aware of the physiological dependency (addiction) of benzodiazepine medication and since then its addictive effects have been well documented (p 638). Indeed, medical prescription in chronic cases of the drug may induce dependency. However, in these cases no abuse, preoccupation with obtaining the substance or interference with the performance of usual social or occupational roles is typically identified (DSM IV p 268-9). From a psychiatric perspective, therefore, it would seem that physiological dependency on psychiatric medication is not a *necessary* precursor to the development of the self-reported maladjusted lifestyle presented by Dan during the research process (see p 769) - 'personality' variables appear to be the identified mediating factor predisposing lifestyle adjustment as defined by Axis II taxonomy.

In this regard, Dan met the minimum five criteria for a diagnosis of Borderline Personality Disorder since he displayed the following symptom patterns during the course of the research process:

- Criterion 1: frantic efforts to avoid real or imagined abandonment.
- Criterion 4: impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
- Criterion 5: recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
- Criterion 8: inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- Criterion 9: transient, stress-related paranoid ideation or severe dissociative symptoms.

That is, firstly, Dan experienced intense and persistent fears that he would be abandoned by both Harry and the Enoch's (Criterion 1: see p 625, 700-2); it seemed to me, however, perfectly understandable given his resistance to independent income generating work and the limited options that this choice provided Dan - Harry and the Enoch's were literally the only barriers between Dan and a life on the streets, a fact which Dan referred to repeatedly during the research process. Secondly, Dan was extremely impulsive with regards to both substances and sexuality (Criterion 4: see p 626-7) since he frequently 'cruised' and partook in promiscuous homosexual activity. Dan however understood the latter activity to involve attempts at establishing a possible intimate relationship with another man other than Harry (see p 634-5) and male companionship more generally . Thirdly, Dan's first suicide attempt (Criterion 5: see p 637-638) occurred in conjunction with withdrawal from benzodiazepine medication after the psychiatric community had become aware of the addictive nature of benzodiazepine. Dan had been taken off the drug and had suffered severe

anxiety and insomnia; the resulting distress culminated into serious self-mutilation of his wrists with the intention of ending his life to relieve his emotional pain during the withdrawal - only emergency intervention saved him (see p 637-638). Thereafter, any other suicidal gestures seemed largely substance related through overdosing - it was not always clear whether or not the life threatening overdosing indicated a form of self-mutilation or damage, or was simply part of the cognitive distortion precipitated by the substances themselves; indeed, Dan did not wish to die and this seemed his overarching motivation for wanting to dispense with his substance dependency and abuse (see p 782-783). His persistent overdosing, however, did function as a recurrent *threat* of suicide for Dan's caretakers, which positioned him as a high risk patient for actually killing himself, intended or not. Fourthly, Dan reported that he experienced great difficulty controlling his anger (Criterion 8: see p 721-733) in relation to significant people in his life and to God; he experienced himself as lacking self control in this regard. I however found his anger to be largely congruent with his situation, expectations and story-lines and I did not witness any significant anger related problems that might have interfered with the research process. Finally, Dan displayed dissociative symptoms (Criterion 8: see p 735-8) at one point during the research process when he declared himself to be 'deaf' although his 'deafness' disappeared quickly and seemed rather to occur in selective environments, such as the psychiatric half-way home or with Harry from time to time, within a clearly defined interpersonal context and functioned as might any speech-act for interpersonal positioning.

Dan also displayed many *other* personality traits typical of the B-Cluster Personality Disorders:

- Antisocial: 'impulsivity or failure to plan ahead' (Criterion 3); 'reckless disregard for safety of self or others' (Criterion 5); 'consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honor financial obligations' (Criterion 6). Although the diagnostic features require the presence of only three criteria for diagnostic qualification, there was, however, no clear evidence of Conduct Disorder before the age of 15 years old and therefore Dan could not be diagnosed as an Antisocial Personality Disorder.
- Histrionic: 'is uncomfortable in situations in which he or she is not the center of attention' (Criterion 6) (see p 594); 'shows self-dramatization, theatricality, and exaggerated expression of emotion' (Criterion 6) (see p 594); 'is suggestible, i.e., easily influenced by others or circumstances' (Criterion 7)(see p 594) - five diagnostic criteria need to be present for diagnostic qualification.
- Narcissistic: 'has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)' (Criterion 1) (see p 651-5); 'believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high status people (or institutions)' (Criterion 3) (see p 651-5 and 675-678); 'has a sense of entitlement, i.e., unreasonable expectations of especially favorable

treatment or automatic compliance with his or her own expectations' (Criterion 5) (see p 675-678) - five diagnostic criteria need to be present for diagnostic qualification.

Furthermore, Dan *also* met five criteria for Dependent Personality Disorder for the *C Cluster Personality Disorders* and was therefore diagnosable as such according to the following diagnostic features: 'needs others to assume responsibility for most major areas of his or her life' (Criterion 2); 'has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgement or abilities rather than a lack of motivation or energy) (Criterion 4); 'feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself' (Criterion 6); 'urgently seeks another relationship as a source of care and support when a close relationship ends' (Criterion 7) (see p 634); 'is unrealistically preoccupied with fears of being left to take care of himself or herself' (Criterion 8). The DSM IV however points out that while both Borderline and Dependent Personality Disorders are characterized by fear of abandonment, the former diagnosis is applied to individuals who *react* to abandonment 'with feelings of emotional emptiness, rage, and demands' whereas the latter react with 'increasing appeasement and submissiveness and urgently seek a replacement relationship to provide caregiving and support' (see p 634). The former is also distinguished 'by a typical pattern of unstable and intense relationships' rather than obsessive attachment to one person at a time - unfortunately, Dan displayed all of these characteristics in one form or another, which makes definitive diagnosis difficult.

Moreover, Dan could have qualified for Antisocial Personality Disorder except for the absence of any clear indication of Conduct Disorder from an early age (15 years). Unfortunately, retrospective diagnosis of 'Conduct Disorder' is difficult to validate especially since Dan described himself as being irresponsible from a very young age (see p 783) and mentioned childhood and adolescent behaviour which indeed could have been construed retrospectively as disordered conduct, for example, pulling the wings off insects as a child (see p 847) (Criterion 5: 'has been physically cruel to animals'), breaking into the school laboratory to do experiments at night (see p 794) (Criterion 13: 'often stays out at night despite parental prohibitions, beginning before age 13 years'), or lying about being homosexual when he was uncertain of his sexual orientation at the time in order to escape his schooling responsibilities (see p 706) (Criterion 11: 'often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)) - only three criteria out of a possible 15 are required for Conduct Disorder diagnosis before the age of 15 years.

An attempt at a differential diagnosis would, however, therefore suggest that Dan does indeed only meet the *full* diagnostic criteria for Borderline Personality Disorder with any certainty or where comparative frequency is factored into the diagnostic formulation, although this is clearly conflated

with diagnostic features from Dependent and Antisocial Personality Disorders, specifically, as well as Histrionic and Narcissistic features; any overarching taxonomic classification would seem to be somewhat arbitrary since apart from the *display* of affect and uncertainty as to the age of symptomatic onset, it would seem, essentially, that Dan could be fairly diagnosed as a Dependent or Antisocial Personality Disorder. Furthermore, even a generic clustering of identified Narcissistic, Histrionic and Antisocial traits (B Cluster Personality Disorders), a line of argument adopted by Dan's psychiatrist (see p 880), cannot be accounted for due to the conflation of a possible Dependent Personality Disorder diagnosis which is part of the C Cluster Personality Disorders. During the research procedure I found myself asking whether indeed a personality disorder diagnosis of any sort was *useful* in Dan's case since indeed the taxonomic classification of Dan's interpersonal interaction style as a persistent, endogenous, chronic mental illness is not only vague and somewhat arbitrary, but provided the essential discursive pivot upon which Dan could build his 'psychiatric career' instead of formulating alternative adjustment possibilities.

At the close of the research process, Dan was diagnosed with severe essential hypertension which required his immediate hospitalization (see p 992). Before being so diagnosed, both Dan and Harry had informed me that he was only taking a small amount of prescribed benzodiazepine medication to stabilize his mood as he was being progressively weaned off the substance by his psychiatrist, Dr Brown (see p 981). He had also given up smoking cigarettes (see p 954) as well as promiscuous sexual activity (see p 829) over the research period. Furthermore, Dan had only overdosed once since beginning the weaning process, on a small amount of benzodiazepine. This had correlated directly with him having to leave Harry's flat after the holidays to resume his place at the psychiatric half-way home (see p 981). How the diagnosis of physical illness interfaced with Dan's substance dependency, withdrawal and previous abuse or his adjustment problems, for that matter, is uncertain - neither Dan nor Harry provided any explanation and I therefore independently consulted a medical doctor (GP) for a possible medical explanation as to any interaction between the attendant variables; I was informed that it was possible that the hypertension could have been both a result of the previous medication problems or have been masked by the medication given sedative and anxiolytic effect - in essence, it was impossible to ascertain.

While my Axis IV diagnosis can be understood from the orientating discussion to Dan's life adjustment crisis discussed at the beginning of this chapter, the Axis V Global Assessment of Functioning (GAF) Scale scores need to be qualified with further explanation. That is, during the first month of the research process it was clear that Dan was at serious risk for severely hurting himself through his unbridled use of psychiatric medication although there was no clear expectation of death. At the close of the research process, Dan's GAF score was considerably improved given his

determined efforts at controlling both his abuse of psychiatric medication and any other destructive patterns such as promiscuous sexual activity given the AIDS risk; he was therefore not such a great danger to himself (see p 986-7). He was also coping more independently of Harry and learning to cope emotionally without substances (see p 991):

> *Dan: If I just think what has been happening in this last month (turns to look at Harry). So much has happened, I'm talking about internally...*
>
> *Harry: Yes... yes...yes. I mean I've seen for the first time in years and years and years, Dan, you are confronting yourself and it would seem like you had no alternative...*
>
> *Dan: (To therapist) Ja, there was no alternative. There were no pills to pop.*
>
> *Therapist: That's it!*
>
> *Harry: (Nods his head and smiles)*
>
> *Dan: I couldn't phone an ambulence to take me to a psychiatric casualty, and Dr Brown (psychiatrist) is bloody proud of me, she thought it was fantastic that I didn't phone her on her cell phone to freak her out, you know, I phoned nobody ... (turns to Harry) And I don't think I freaked you out too much, did I? I didn't come on too strong?*
>
> *Harry: No, I thought it was all very constructive, creative...*
>
> *Dan: I dealt with things for the first time, you know, so ja... (long pause).* (p 991)

He was living once again with Harry who had been fortuitously given the use of a family member's apartment for two years. Dan therefore felt that he had a two year hiatus from the responsibility of caring for himself, during which time he understood that it was necessary that he develop the requisite life skills to become more independent of Harry and the psychiatric community - he, however, was still unemployed and reliant on money from his disability pension and his family. While Dan's social environment, housing and economic problems (Axis IV) were considerably improved by moving in with Harry, Dan still needed to address his occupation related problems (see p 991-3). Furthermore Dan was still at some risk to himself even though his self destructive behaviour was considerably improved at the time of termination. Benzodiazepine dependency can take years to overcome (see p 958). This together with the need for ongoing monitoring of his substance abuse, which threatened to reoccur given any emotional crisis as this had been his emotional coping mechanism for years, meant that Dan could not be awarded a higher GAF score following diagnostic evaluation at termination.

**Discursive Clinical Formulation**

Dan had been positioned within the psychiatric story-line from a young age by arbiters of correct moral action such as his school principal (see p 889-890), parents, medical practitioners and, of course, the psychiatric community, who granted the ultimate mandate for this positioning. While the

psychiatric patient role was clearly made available to Dan, it seemed that he had also *chosen* to adopt the position for his social identity. This required a certain repertoire of behaviour (speech-acts) and it seems that Dan had learnt the speech-acts, positioning and story-lines necessary to perform the role convincingly. Indeed during the research process, Dan revealed how he played this role when it suited his needs, for example, when ensuring the continuation of his psychiatric disability grant:

> *Dan: Well I have got it (disability grant) for another year and then it will be on a yearly basis which is for me difficult because that means I can't ... I must remain sick enough for a year to warrant the grant for the second year, but at the same time I can't sit on my* **gat** *(bum) either. I am a good actor, I can ... I can go and convince somebody I am very unwell ...*
>
> *Therapist: (Laughs) How do you do that ?*
>
> *Dan: Oh, there are many ways. A few tears and long sighs, "Oh, doctor, I can't take anymore and blah, blah, blah. I don't sleep and I ... I can't even shave in the morning and I hear a few voices and see a few ..."*
>
> *Therapist: (Laughs)*
>
> *Dan: (Laughs) But they are not too stupid themselves either. You must not underestimate psychiatry...*
>
> *Therapist: Ja.*
>
> *Dan: ... they know when you are schizophrenic. But anyway I have got this ... the new outcome that came from the last admission there (state mental home for overdosing) was the fact that they decided to classify me as a 'schizoaffective disorder' ...*(p 643)
>
> *(edited)*
>
> *Therapist: But what do you think of all of this (latest Axis I classification)?*
>
> *Dan: It makes sense. It makes sense. I must marry into the schizoaffective because that's the one they put on my grant...*
>
> *Therapist: Ja, okay. (Laughs).*
>
> *Dan: ...And I want to know if I can safely hide behind it for the next 45 years, "I am a schizoaffective, you know, feel sorry for me, I need a grant!" ...*(p 645)

Dan's deliberate social positioning within the psychiatric story-line clearly indicates the operation of personal agency and self-advocacy in light of his personal identity needs; that is, to feel secure in relation to anticipating the future - his social identity as a psychiatric patient simply facilitated this process. In light of this argument, it would seem, therefore, that this discursive relation between his personal and social identity also fashioned his initial adoption of the psychiatric patient role as a teenager and young adult; that is, the patient role resolved certain discursive disjunctions between Dan's individual-private discursive world, on the one hand, and the story-lines and possible social

identity positions available at the collective-public level. For example, before the age of 13-14 years of age, while at primary school, Dan described his life as follows:

> *Dan: No, there was, there was (positive, good times - in response to the assisted autobiography exercise). I mean my youth, before I went to boarding school, that was fantastic because my father was the principal of all the schools that I was in and he was the headmaster of the boarding school I was in and my mother was the junior matron and I was kind of like the big king there, you know, and carefree days of going into town and pulling the wings off **tok-tokkies** (flying beetle) and things and putting them in pots, eating **veldkos** (bush food) you know, collecting spiders, it was like fantastic. And then the shit hit the fan when I went to the other boarding school, you know...*
>
> *Therapist: In high school?*
>
> *Dan: Ja, in high school.* (p 847)

Dan describes his high school experience as traumatic by comparison since he was quite unprepared for the autonomous childhood (early adolescence) world (see Chapters 3 & 7). Not only had he experienced what seemed to be a somewhat protected and privileged position in his childhood world with his parents, but certain pivotal family story-lines sharpened the discursive disjunction between the two worlds. That is, firstly, his parents never fought or got angry and his father apologized after giving hidings, for example; the family emotionology clearly outlawed aggression (see p 721). On the contrary, however, the autonomous childhood world *demanded* that Dan participate in ritual aggression of sorts, yet he was unable to meet its challenges given his social history. Secondly, the discursive disjunction was sharpened even further by the apparent family story-line involving a division of labor between the sexes in relation to child rearing and income generation; that is, Dan reports that his mother exclusively cared for the children while his father remained obsessively attached to his career and could spare little time for his children (see p 598-9, 709 and 890). Dan described his father as being completely absent for him as a son, therefore (see p 602). This together with his birth order (see p 603-606) between an elder (2-3 years) and younger sister (approx. 1 year) appeared to have limited Dan's uptake of typical masculine speech-acts, story-lines and positions, preferring to play classical music, for example, to the rough and tumble, dominance hierarchy games of the autonomous childhood world - indeed Dan describes himself as follows:

> *Dan: I was very effeminate when I was young. I was a real little queer...* (p 710)

He was therefore persecuted both physically (repeatedly beaten up) and socially (ostracized) at high school by the other boys yet was unable to inform his parents. He had been sent to boarding school given his parents' geographical relocation in order to facilitate his father's career mobility. Furthermore the Afrikaans-speaking, Calvinistic community of which his family was a part tended to favor an authoritarian position on child rearing (see p 704-705). Any voiced dissatisfaction would

have upset the family's plans which he had understood to be unchangeable. Dan had therefore suffered alone with his discursive ineptitude rather than risking confrontation with his parents and father especially, who tended to doggedly pursue his career to the exclusion of all else - Dan therefore had no legitimated voice to initiate his emancipation from an untenable social reality as he experienced it at the individual-private level (see p 704-707) - his personal agency had been compromised through the discourses which comprised his world as a young person amongst others, as a social being.

Another important familial story-line explaining Dan's uptake of the patient position had to do with a history of mental illness (see p 600) within Dan's family; his father's sister had spent 7 years bedridden in a mental hospital, unable to recognize her children and husband while Dan's mother's brother (both orphaned) had killed both himself and his daughter. When Dan's father had been called in by the school headmaster to inform him that his son was homosexual and needed, therefore, to be treated by a psychiatrist, Dan's father, who was fully versed in the psychiatric story-line, simply complied with the directive; this was a point of discursive congruence between the two worlds. However, he was unconscious of the fact that Dan had previously been told by the principal that homosexuality needed to be treated as a mental disorder and had admitted to this only as a way of escaping boarding school (see p 889-890), thereby acting with personal agency given his voiceless position as a young person:

> *Therapist: And the principal sent you there?*
> *Dan: He got my parents to come and fetch me and he recommended it...*
> *Therapist: Because you were gay?*
> *Dan: Because I was gay. I was put into hospital and put onto a drip with sedatives in ...*
> (p 706)

Ironically, the agential *resolution* of Dan's discursive disjunction between the autonomous childhood world and his personal identity was through embracing psychopathology.

These traumatic mid-adolescent experiences were reinforced a few years later when Dan was alone at university and was faced with yet another discursive disjunction challenge; that is, he could not cope with the academic gap between schoolwork and tertiary level education. Dan had always done well at school with relative ease and therefore could not adjust to the new responsibilities the work load demanded (see p 771 and 794). He was also used to the comparative structuring of his life by others since his parents were both institutional workers as was the high school boarding environment and the institutional hospital context; at university he had to structure his own activity. Furthermore, Dan was already on prescribed psychiatric medication for anxiety as a matter of course which also

interfered with his studies. After a number of aborted attempts at tertiary education and entry into a *professional* career (e.g., musician (see p 771 and 774-5), nurse (see p 794), or translator and teacher of foreign languages (see p 845-6)), Dan attempted to generate income by engaging in menial or clerical work usually supplied by family members. However, he did not find the work stimulating or rewarding and therefore tended to be irresponsible. Thereafter, Dan was once again hospitalized in a mental institution with his father's support:

> *Dan: So I went home and the first thing I said to them is that they must take me to a mental hospital because I realized there was something wrong with me. And the closest I could come to naming what was wrong with me was my 'gayness'. You see I didn't understand enough about one's personality and its make up, what it takes to cope and what is going on with me over there ...(so) he (GP) referred me to a doctor where they did aversion therapy, as you know. And I think my psychiatric career started there because I spent about five months there, um, felt very unhappy, you know, the therapy did nothing for me, but I was amongst people that were also a bit fucked up, you know. It was safe there. It was contained. It wasn't the outside world even though it was fucked up. Nobody made more demands on you than is appropriate for you. As long as you had your morning shave and you attended the ablution sessions and you washed after lunch as you were assigned to, they praised you, "You're a good boy," in that place. You don't get recognition outside for the little things that you get it for inside there, you know.*
>
> *Therapist: Mmm...mmm.*
>
> *Dan: So I think my addiction to psychiatry really started there. Because I very soon started when any crisis happened, running to (state mental hospital), you know. As the files grew thicker and thicker there, so my file is ... They think I am a very disturbed person and they are baffled by it because nobody knows really what is going on with me.* (p 795)

Since 16 years of age, therefore, Dan had been involved in ongoing psychiatric treatment for almost thirty years. Moreover, at the time of the research procedure, he simply could not afford to 'get better' as he was *wholly* invested in the psychiatric role (see p 959) both in terms of his social and personal identity. In order to explicate this discursive reality for Dan, I coined the term 'psychiatric career' since Dan's social identity positioning efforts within the psychiatric story-line were no different at a meta-theoretical level to positioning strategies within any 'earning-a-living' story-line where individuals take up 'career' positions in order to make financial provision for themselves, or *any* 'moral career', for that matter, regardless of the story-line.

Similarly, Dan's personal identity was reflected (in part) through the social identity choices made in adulthood, as is the case with all people. Indeed Dan seemed to rely on his psychiatric patient status

as a way of presenting himself to himself and others as 'the fallen creative genius'; like so many great Western creative thinkers, writers and artists generally, Dan had fallen prey to mental illness (see p 793-4), so the implicit story-line read. He wrote Afrikaans poetry and could play over 2000 piano pieces by ear which reinforced this personal identity since these were believed by both himself and Harry to be his natural affinities (see p 634). With Harry, Dan was surrounded by sensitive artists and friends and therefore once again he was reliant on his social identity status for social membership which in turn informed his own sense of personal identity. Furthermore, Dan had been positioned in an 'achievement' story-line in his family. For example, Dan had always been in the shadow of his elder sister who had achieved extremely well at university both academically and socially (see p 608), and his father had always been very achievement orientated in his own career. Dan mentioned both his father and sister's relation to 'achievement' of his own accord during his first session. Therefore, by taking up the 'mental patient' social identity, Dan could achieve without achieving, so to speak, since in essence, Dan could always be excused from failure because he was a 'mental patient' yet, paradoxically, would always be 'the fallen creative genius' given this role. In this way Dan could avoid any performance anxiety and sense of failure. While this no doubt was an unusual and creative use of personal agency and self-advocacy, Dan simply became progressively more cemented into his mental patient role, along with all the attendant speech-acts, such as regular overdosing, acting irresponsibly, 'cruising' and remaining unemployed.

Furthermore, at the personal identity level, there appeared to be constant discursive disjunction between Dan's interpolation of the patient position within the psychiatric story-line and ongoing social pressure for Dan to take up productive, income generating work; that is, when I asked Dan to complete the phrase 'I must…' in Afrikaans, he immediately and recurringly heard his mother's voice saying, "Jy *moet* werk!" (You *must* work!) to the absolute exclusion of all other thoughts (see p 712). This personal identity disjunction therefore seemed to cause anxiety and depression in and for itself. These understandable emotional assessments were however interpreted by Dan, his father and the psychiatric community as indications of his fragile mental state; of course, more medication was prescribed given his full time social identity role, and inevitably Dan would end up overdosing in one form or another, intended or not, which in turn would reinforce both his psychiatric patient positioning and his personal identity disjunction, ad infinitum.

Dan's psychiatric moral career also seems to have been assisted through his friendship with Harry who had made material provision for Dan since his early twenties. While Harry was opposed to Dan's use of psychiatric substances, on the whole, it seems that Harry focused on intrapsychic explanations of psychopathology which only served to maintain Dan's clinical picture. For example:

- both Harry and Dan entertained explanations centering on past life regression given Harry's strong belief in reincarnation; that is, he seriously considered Dan to have been involved in a Nazi concentration camp during the holocaust after which he had not been able to come to grips in *this* life with the mother he had tragically lost in his previous life - this Harry felt explained Dan's symptoms (see p 772-3);
- Harry also believed strongly that Dan's mother's pregnancy had contributed to his difficulties: his mother had to undergo surgery during the 7th month of being pregnant with Dan and involved strong sedative medication (see p 759). Dan informed me that he had spent a year in treatment with a rebirthing therapist but there had been no improvement in his symptoms (last session, unrecorded).
- as a trained Jungian therapist, Harry tended to conceptualize symptomatic behaviour in terms of intrapsychic structures, such as archetypes, complexes, etc.. (see p 757)

Given these story-lines, Harry had therefore been sympathetic and supportive of Dan throughout their relationship especially when he had overdosed or was in some kind of critical condition. Harry wanted to keep Dan alive at all costs and although he was aware of Dan's attention seeking behavior, he felt forced to answer any of Dan's calls for help (see p 779-780) - unwittingly, however, this co-dependent behavior only served to maintain Dan's self destructiveness; no 'cure' was possible since Dan relied on self-destructive behavior to secure his psychiatric career, central aspects of his personal identity and his emotional and material dependence on Harry. The complex operation of these discursive structures was however largely unconscious to all involved parties; every effort at a 'cure' only resulted in deepening Dan's investment in the psychiatric role (social identity). In addition, the psychiatric medication had deleterious effects on his cognition, memory, emotional frustration tolerance levels and of course his physical health, all of which made it increasingly difficult for Dan to develop occupational skills and to function independently, both materially and emotionally, of Harry, his parents and the psychiatric community.

When Harry retired, therefore, Dan was indeed alone and had only the psychiatric community to which he could turn. After a few aborted attempts at living in communal living arrangements on his very limited budget, Dan had chosen to settle at the Enoch's half-way home. He however found that the psychiatric half-way home was a far cry from his comfortable life with Harry and in effect, the resulting discursive disjunction resulted in yet another discursive challenge for Dan. Moreover, Dan's discursive reality was once again undermined when Dan's psychiatric disability grant was revoked with no clear future certainty as to his psychiatric diagnostic qualification as a Borderline Personality Disorder for state benefits. Indeed, Dan had been abandoned by the two structures that had previously supported him; that is, Harry and the psychiatric community. As expected, Dan therefore held on ever

more tightly to his psychiatric role and, predictably, his symptoms worsened accordingly. However, through this crisis at the age of 45 years old, Dan became aware of how tenuous his adjustment was to the world of others; *circumstances* had forced him to become painfully aware of his need to develop alternative methods of securing a sense of personal agency. Unfortunately, Dan believed that he lacked the necessary resources and skills to re-author his social and personal identity given his psychiatric status as a mentally ill person and found his new discursive challenge very intimidating. He described this reality in the following terms:

> *Dan: I said to Dr Brown (psychiatrist) yesterday, and I tell you, it is the absolute, gospel truth, I said, "I feel like a fucking fish under the ocean...". You know, those fish that jump up to the surface occasionally (does dramatic enactment of fish jumping out of the water) and I see on the shore these people sitting and shouting at me, "You know, you, you've got to develop little legs so that you can crawl up onto the land, " (enacts this struggle as if really struggling) you know...*
>
> *Therapist: But you want to say back to them, "But hang on, you know, I am a fish and I live deep under the ocean, and I can't just do that suddenly." ...*
>
> *Dan: ... then I want to go down into the dark ocean again. (He enacts this) ...*
>
> *Therapist: Ja...ja...*
>
> *Dan: ... it is like that, exactly like that, you know...* (p 968)

What follows below, therefore, is a discussion of the therapeutic positioning strategy that I adopted through the co-inquiry project which Dan and I undertook in order to both assist me in completing this doctoral thesis, and to assist Dan to an improved lifestyle as I understood this as a discursive therapist and researcher.

## THERAPEUTIC POSITIONING

### Psychiatric

I deliberately submerged the psychiatric story-line in this particular case study since Dan was already deeply entrenched in the patient role. I therefore attempted to 'normalize' (see REBT below) rather than 'pathologize' his experience; that is, where Dan understood his experience to be indicative of psychiatric pathology, I would reframe (systems-theoretical) the issue at hand as understandable given his circumstances, history and belief-systems. By demonstrating the so-called 'normality' of Dan's thoughts, feelings and behaviour, it was possible to assist him in moving beyond his psychiatric label and find alternative ways of meeting his social and personal identity needs. In this manner, I attempted to restore a sense of personal agency and self-advocacy by pointing out to Dan

how he had gone about solving his life through the psychiatric patient position; by implication, Dan could choose alternative story-lines, positions and speech-acts within which he could fulfill his personal identity needs. I therefore framed his psychiatric moral career as 'non-optimal agency' (see p 888) since the psychiatric position is extremely limiting given that emotional pain or overdosing antics, for example, are intrinsic aspects of the speech-act repertoire of the position; in Dan's case these were obligatory social acts in order to ensure his continued role as an actor within the psychiatric story-line (see p 710).

I used 'normalizing' as an overarching intervention principle throughout the therapeutic positioning process in multiple forms whenever the therapeutic moment presented a possible opportunity. For example, Dan referred to the pathological nature of his aggression towards a number of undeserving people such as Harry or people who had tried to help him in the past, and he even admitted that he felt aggressive feelings towards me. Criterion 8 of the Borderline Personality Disorder criteria also outlines aggressive displays and control difficulties as indicative of psychopathology; Dan had clearly taken up this position which the psychiatric emotionology had made available. Please refer to transcripts (p 717-734) for the therapeutic positioning process adopted for normalizing Dan's 'anger'.

Similarly I challenged Dan to alternative conceptualizations as to the origin of his so-called psychiatric illness by contesting the psychiatric story-line pertaining to biological primacy; that is, Dan opened the co-inquiry in the first session with a 'genetic' explanation for his life adjustment difficulties and quoted the incidence of psychiatric illness in his younger sister and various other extended family members from the past as proof of his inherited constitutional anomalies (see p 600 and 605-6). This also correlated with the psychiatric view that personality characteristics are biological in origin, of which Dan was fully aware (see p 880). I however countered this position by bringing these assumptions into question at a scientific level by, firstly, providing Dan with critical commentary on research difficulties (trait-gene correlation studies) into genetics (e.g., through alerting him to a Time magazine article questioning the scientific validity of correlation studies as well as providing an alternative discursive psychology formulation (see p 867-9 and 901)) and, secondly, by pointing out the implications of these discursive assumptions in relation to personal agency; that is, the overriding properties of human volition and the contribution of historical and local social factors on genetic predisposition and their ultimate manifestation (see p 605). This discursive positioning seemed important as a way of perturbing Dan into alternative story-lines and positionings on his life adjustment problems.

Dan was grateful that I was able to stand outside of the psychiatric therapeutic system as a researcher; the independent co-inquiry, life-story approach provided a forum which precluded social identity

presentation (game playing) constraints given his dependency on the psychiatric community (see p 899 and 853-4). In this way, Dan was able to gain perspective on his psychiatric moral career and formulate alternative coping strategies. However, where appropriate I did reinforce the prescribed use of psychiatric drugs (see p 736) within the overarching therapeutic story-line of Dan 'refining his psychiatric career' (see p 687-9, 820-1 and 977), rather than replacing it with an entirely different moral career, which would serve as preparation for the formulation of an alternative social identity unrelated to his position as a psychiatric patient eventually.

**Psychoanalytic**

We explored Dan's past in order to contextualize his current circumstances within the story-lines and positions comprising his socio-historical heritage and included discussion with regards to his family of origin (see p 598-614 ), adolescence (see p 701-7), early adulthood (see p 707-9) as well as Dan's more recent past (see p 718-9). This provided important background information for me to understand Dan more fully and facilitate the therapeutic positioning process more effectively. However, as a therapeutic tool any retrospective analysis for enhancing self awareness of implicit story-lines and positions Dan had not found especially useful in initiating any *shifts* towards improved lifestyle adjustment prior to the co-inquiry. Indeed he mentioned during his first session that he had discussed his familial origins on numerous occasions with other therapists and that any 'insights' had failed to assist him with his 'personality' problems (see p 612-4). He even pointed out that he was aware of the need to take responsibility for the past and not use it as an excuse for immoral activity (see p 612), although this too had been entirely ineffective in moving Dan beyond his psychiatric social identity. After this first session, I therefore de-emphasized focusing on his family of origin during the life-story research and rather considered Dan's *overall* social history during the process, so to reveal the implicit story-lines and positionings which had characterized Dan's discursive world and provided the discursive metaphors through which he had chosen the psychiatric patient position - in this way the development of insight and self awareness could be facilitated through a broader socio-historical exploration than familial influences alone. This therapeutic positioning proved useful since Dan seemed to make important links with some of the current problems he experienced and the story-lines and positions from his past which highlighted the constructed nature of his discursive reality; by implication, he could *reconstruct* himself. For example, Dan also traced his uptake of the 'fallen genius' story-line to his boarding school experiences where he had worked hard to be a star pupil in order to create an alternative source of social honor which the other boys would respect - this functioned as a discursive buffer against social circumstances which threatened to overwhelm Dan as a young adolescent (see p 869-870). On the other hand, I suggested that this together with his need for social honor next to his competent elder sibling ultimately explained the origin of his investment in the 'fallen genius' story-line (see p 867-870) although the story-line was always available at a

cultural level. Furthermore, Dan traced his fear of abandonment and being alone (see p 701-2) as well as some instances of inappropriate aggression (e.g., towards previous lovers (see p 721-2)) to his experiences at boarding school. Through this therapeutic positioning, therefore, it was possible to demonstrate to Dan that some of his primary Axis II symptoms (abandonment (Criterion 1) and aggression (Criterion 8)) indeed had an understandable historical discursive basis structurally isomorphic with the emotionological development of any so-called 'normal' person.

Similarly, the rep-grids revealed historically evolving discursive constructs which made the seemingly irrational rational. For example, together we traced Dan's movement into the obverse position within the story-line 'achievement at all costs' inculcated by his father - from Dan's position as a youngster, this story-line had emotionally deprived him of a father and resulted in his voiceless incarceration at boarding school after which his father then lost all his money on the stock exchange at the end of his career; he therefore refused to take up his father's position within the story-line, preferring to relocate himself into the dialogical position (see p 670). We integrated these insights with other positions and story-lines available to Dan as expressed in the rep-grids (see p 616-7 (topic: earning a living), p 755 (topic: achievement) and p756 (topic: caring and support), for example, Harry's 'spiritual law of abundance' and 'God will provide' story-line, and Dan's inability to complete the rep-grid on 'caring and support' given the painful emotional loading of these ideas for his relating to others (see p 782), with my alternative suggestion of the story-line 'sometimes you simply need to earn money to pay for the things that you want' (see p 680-1).

Other self-awareness raising therapeutic methods to facilitate 'insight' included Dan's observation of himself on video so that he might see for himself the deleterious effects of psychiatric medication (abuse or otherwise) on his discursive presentation during therapy (see p 689-695). I also interpreted Dan's awareness of the presence of the video camera during therapy as his 'mother's critical eye' (see p 862), given the therapeutic moment, since he would apologize to the camera from time to time for any perceived impropriety on his part. By using this psychoanalytic metaphor, I attempted to heighten Dan's self-awareness of his sensitivity to social conformity and pressure albeit that he simultaneously understood himself to be socially irresponsible. This occurred within the overarching story-line of personal agency which I actively mediated to Dan by explaining this at a theoretical level (see details under narrative therapy below) (see p 678-689). This helped preempt possible integration of the two obverse (dialogical) poles of the 'social responsibility' story-line given both injection of the new discursive material into Dan's discursive world and his heightened self awareness of his own discursive constructs.

Dan also used psychoanalytic rhetoric as speech-acts during the therapeutic positioning process, usually as a way of mystifying 'the unconscious forces beyond himself' which propelled him inevitably towards one or another form of irresponsible behavior (e.g., see p 784) such as substance abuse and shoplifting (see p 788). I therefore contested any explanation involving 'unconscious forces' provided by Dan by perturbing him into considering other story-lines or positions. For example, Dan explained an overdosing episode which occurred in his sleep as motivated by a 'death wish', while I suggested that given his anomalous neurochemistry, he might well have simply forgotten and, furthermore, he required the overdosing tactic as a way of securing his disability grant! (see p 895-7)

*Social* adjustment issues are not addressed at all in this story-line. It must also be emphasized that the Kleinian psychoanalytic story-line is a mainstream clinical psychology formulation often used for explaining the bizarre behaviors typical of the so-called Borderline Personality Disorder, and one which many of Dan's previous therapists would have used to understand and explain his behavior, as did Harry given his theoretical training to which Dan actively referred during the co-inquiry process (see p 717-720). I however deliberately avoided this line of analysis except in passing once Dan had raised it (see p 717-733), since as a position within the discursive therapeutic context, this story-line limited the perlocutionary force (see Harré, Brockmeier & Muhlhausler (1999)) for further discussion on the limits of discourse on effective action) of any possible therapeutic positioning in Dan's case; that is, any analysis drawing parallels between Dan's infancy and his current lifestyle adjustment (or where Dan and I played out and restructured these intrapsychic conflicts through the transference relationship with no active voicing of these constructs) amounted to a redundant therapeutic positioning strategy for the realization of Dan's therapeutic goals which were largely centered around *social* adjustment.

It seems, therefore, that the reason for this redundancy is that at a formal level the explanatory psychoanalytic story-line pertaining to the Borderline Personality Disorder comprises the same *form* of argument as the other explanatory story-lines already considered in this chapter - 'unresolved trauma from past lives', 'interrupted pregnancy' and 'genetic loading'. All of these therapeutic story-lines are simply *not provable* one way or another, yet each served as *moral justification* at the social-collective level for Dan's self reported lifestyle adjustment problems at some point during therapeutic efforts in his thirty year investment in a psychiatric moral career.

This formal level conceptualization might therefore explain why previous psychoanalytically orientated therapeutic interventions had been unsuccessful in restoring psychological health to Dan; he was a passive object in the story-line reliant on an external, expert agent (e.g., psychoanalytic

(object relations) therapist, rebirthing/ primal therapist, clinical hypnotherapist /psychic (past lives), and psychiatrist or genetic engineer/consultant) for any initiation of positive changes in his lifestyle adjustment. However, since all of these clinical formulations could not address Dan's lack of appropriate life-skills for his adjustment outside of the psychiatric context, or his psychiatric medication addiction or their side affects, or, most especially, his reliance on the patient role to *solve* his social and personal identity dilemmas as a social and personal being, it would seem to me that all were doomed to failure. Please refer to Dan's comments on his direct experience of psychoanalytically orientated therapeutic intervention to contextualize these important meta-theoretical assertions within the pragmatics of therapeutic discursive psychology (see p 597-8 and 823-5).

The reader might also refer to the following for further psychoanalytically orientated ideas in the context of discursive therapy with Dan:

- discursive slip - 'game/gain' (p 854); there were also numerous other slips with similar underlying discursive structure throughout the co-inquiry process.
- counter-transference - my need for structure (p 871); my work load and the co-inquiry project (p 922, 925-6); working with these counter-transference issues therapeutically (p 960-6).

**Cognitive-behavioral**

Therapeutic positioning involved actively *mediating* the following aspects in order to facilitate the development of personal agency in Dan's discursive positioning in the world of others, as understood by him; that is, skills, structure, meta-thinking and pragmatism;

- skills:

- pertaining to problem solving (se p 667-74) and career adjustment (see 911); for example, when Dan argued that his poor CV presented a double-bind obstruction to future employment possibilities on the open market, we considered alternative income generating options, for instance, selling the Big Issue magazine (sold by the unemployed) which involved free training and could also be sold on the local trains because Dan had flatfeet and weak knees (p 900-3 and 933);

- encouraging Dan to focus on the interpersonal skills he had acquired through his relationship with Harry in establishing agency with regards to a future relationship (see p 663);

- reinforcement of positive coping mechanisms over self destructive behaviors; for instance, when Dan gave up smoking and benzodiazepines, I suggested that he replace these with a positive activity - he chose walking (see p 806-7);

- considering alternative daily behavioral routines in order to maintain his controlled use of psychiatric medication (see p 807).

- structure: for example, by circumscribing the number of co-inquiry sessions, Dan became aware of his destructive discursive positioning over the duration of the scheduled sessions; that is, he regretted his persistent overdosing since it had deprived him of many co-inquiry sessions (see p 797).
- meta-thinking: together we explored structural aspects of Dan's thinking processes; for example, the structural relation between thinking and emotion and the formal structures pertaining to any emotionology. We considered how these were specifically applicable to Dan's discursive content, such as the generative mechanisms supporting anxiety and depression as emotional assessments (see p 711, 810-820 and 945-6). In order to assist him with specific agential application of these ideas to his own life, I also, firstly, pointed out to Dan that medication interfered in the discursive signal function of his emotions; negative emotions were simply discursive messengers destroyed through psychoactive medication (see p 946-7), and, secondly, I also sharpened his awareness of his voluntary cognitive control over his discursive constructs for anticipating his future. This was achieved through assisting Dan in reconstructing some of his primary self *expectations* through which his emotions were interpreted as discursive metaphors; for example, Dan acknowledged that he often calmed down sufficiently *before* taking any anxiolytic medication, thereby demonstrating the power of discursive anticipations as regulators of our emotional experiences (see p 814). I used this structural insight into the generative mechanisms regulating affectivity during the co-inquiry process, to demonstrate to Dan through logical argument (see 807-826) how he could alter the structure of his beliefs about anxiety and, in so doing, his manifest experience of it. I also mediated the overarching story-line, "It's okay to feel negative emotion, just take a step back and learn from the emotion", within the overall demonstration so to reinforce the practical implications of these ideas.
- pragmatism: I framed any dilemma experienced by Dan in terms of pragmatic consequences; for example, Dan considered past life experiences to be responsible for a recently returned stammer in his speech, and while I refrained from pursuing any explanation for the emergence of the stammer, I focused on the fact that he was coping admirably through circumlocutions, to which he had previously confessed (see p 847-8).

The following Rational-Emotive-Behavioral Therapy (REBT) principles (see also 'psychiatric' above) were applied throughout the therapeutic restructuring process, and were often integrated with general skills mediation:

- *normalizing*: for example, both Dan and Harry referred to the possibility that Dan suffered from some unidentified mood disorder such as 'manic-depression' which is typically understood to have a physiological origin. Dan indeed often described himself as 'manic' as did Harry from time to time. I would therefore frame 'manic' behavior as 'normal' within the rationale of Dan's social

circumstances; for example, he described himself talking compulsively to Harry as 'manic' behavior, for example - I normalized this by pointing out that given his emotional reliance on Harry and their forced separation, he was simply catching up with an old friend (see p 836); or where Dan described his carefree lifestyle at university as a youngster as 'manic', I pointed out that indeed his behavior was not uncommon amongst young adults in tertiary education and students more generally (see p 845-6).

- *realistic self-talk*: for example, Dan felt somewhat guilty since his disability grant was funded through tax payers money. I however modeled self-talk which side stepped guilt issues and focused on the pragmatics of his situation and his intended action to strengthen himself through the grant until he was strong enough to dispense with it (see p 821).
- *logical argument*: I used didactic rhetoric through the therapeutic positioning process to effect discursive reconstruction so to reposition Dan in terms of his therapeutic goals. For example, Dan attempted to put into practise his previously identified option of masturbation as a natural tranquilizer and alternative coping strategy to induce relaxation when anxious, as opposed to psychiatric medication overdosing, for example. Unfortunately he found the experience unpleasant and exhausting. He ascribed this to warnings about excessive masturbation and quoted religious authority on the matter (see p 842-3). It seemed to me at the time that this echoed a broader submerged story-line in Dan's life pertaining to sexuality and religious guilt. In an effort to restructure his emotionology around these central discursive themes constructing Dan's reality so to reduce his anxiety, which was one of Dan's major therapeutic concerns, I therefore pointed out that his resulting displeasure may have been linked to his misuse of psychoactive chemicals and that indeed no medical evidence existed for health deterioration given 'excessive masturbation' in the amounts he described (once or twice daily); sexually active couples often enjoyed this frequency as a matter of course in their daily lives (see p 843). I reinforced these ideas still further by citing psychological research evidence which suggested that intelligent, educated people tend to masturbate more frequently than less educated people; that is, the former are able to generate fulfilling sexual experiences through the power of fantasy, while the latter need to rather act out their fantasy in order to reach fulfillment given their intellectual inferiority. By deliberately citing research authority and giving Dan the choice of positioning himself as 'intelligent or unintelligent' within the mediated story-line, and considering his self belief with regards to his superior intelligence, I was able to assist Dan in reformulating his discursive constructs in a direction he preferred (see p 843-9).

Finally, I provided important feedback to Dan in relation to his therapeutic goals throughout the therapeutic positioning process and used positive reinforcement (see p 821); negative feedback (see p 845); rating scale (see p 750 and 752).

**Humanistic**

Typical Gestalt techniques were not used during this case study simply because no therapeutic moment seemed appropriate for their implementation, in my opinion, or other methods appeared more useful for effecting Dan's therapeutic goals. However, client-centered as well as existential techniques and principles were integrated with the general therapeutic positioning strategy. Furthermore, this strategic process also forced my consideration and application of 'Maslow's Hierarchy of Needs' (Maslow, 1976, 1959, 1954) to the clinical context although this formulation is typically associated with theoretical as opposed to therapeutic psychology. This forced positioning occurred due to *Dan's* invocation of this discursive schema during the therapeutic positioning process in order to position me as therapist; my counter move required the uptake and reworking of Dan's deliberate positioning within this story-line (see p 904). This unexpected story-line became pivotal in the discursive reconstruction process thereafter and we therefore turn now to a full consideration of these therapeutic developments before briefly discussing the contributions of existential and client-centered approaches to the therapeutic positioning process with Dan.

*Maslow*

Dan persistently positioned himself within discursive metaphors which forced practical considerations into the background, while he embraced those supporting 'inner experience', 'aesthetic sensibility' and the like. This discursive position obviously contributed to maintaining Dan's social identity status quo and might be considered a sub-theme within the 'fallen creative genius' story-line, with similar implications for pragmatic action. During a therapeutic positioning sequence where I was contesting this kind of discursive construct, Dan predictably repositioned himself in terms of his typical assertions although during *this* particular therapeutic moment, he chose to quote Maslow's Hierarchy of Needs as legitimate authority, citing the ascendancy of discursive constructs such as 'self-actualization' (or 'inner experience' etc.) over 'practical necessities':

> *Dan: No, I think that life goes beyond just those superficial things. It's about having to find meaning in your life...* (p 905)

It appeared to me therefore that this was a prime therapeutic positioning opportunity to assist Dan in his reconstruction of this central story-line which threatened to maintain his psychiatric position indefinitely; that is, by definition, the base of the pyramidal hierarchy relies on the fulfillment of 'basic needs' before it is possible to fulfill needs located at higher hierarchical levels, such as 'self-actualization' which is at the pinnacle. It was possible therefore to not only restructure this central story-line by challenging Dan, but Maslow's formulation also provided the ideal conceptual metaphor for the exploration of Dan's life adjustment more generally. That is, I demonstrated how the so-called

'normal' person might utilize the schema as an index of their life adjustment by pointing out, firstly, how *my* needs as a therapist were met for 'biological necessities (eating, sleeping etc.), security (safety and shelter), social (belonging to a group), self esteem (feeling worthwhile) and self actualizing or fulfillment (need to develop skills, interests and talents)' in my life adjustment, and, secondly, we explored how living at the psychiatric half-way home indeed also met Dan's needs - structurally speaking, the two worlds (therapist and patient) were identical (see p 942). Furthermore, as a metaphor, Maslow's schema has indirect conceptual correlation with discursive psychology formulations in that it incorporates implicit allusion to personal agency since the individual pursues 'inner happiness' within the confines of social and physical being. This strategy therefore also supported any 'normalizing' efforts while simultaneously supplying Dan with a conceptual schema as to the relevant focus areas for the slow but steady improvement of his life adjustment through exercising personal agency. As a metaphor, this schema illustrated to Dan that indeed his present life adjustment held the potential for self-fulfillment should he choose to refine his psychiatric career; he need look no further than the psychiatric half-way home. By implication, therefore, Dan would be forced to deliberately develop agential skills in meeting this challenge, which would necessarily pave the way towards a natural progression out of the psychiatric role. Dan began implementing this during the research process where, for instance, he attempted implementing alternative speech-acts and took up alternative positioning within the discursive practices of the psychiatric half-way home. For example, he started being more humorous and pleasant with Mrs Enoch instead of fighting (see p 916-8). This line of reasoning inspired the agreement between Dan, Harry and myself towards the close of therapy that Dan would live at the half-way home during the week and spend week-ends with Harry in his new flat in Cape Town - this, it was understood, would provide the ideal living arrangement to facilitate Dan's repositioning as a psychiatric patient through the development of personal agency skills (see p 984-991). Unfortunately, Harry's comfortable flat beckoned too strongly for Dan and as usual, Harry consented; he therefore chose to forgo the lessons in personal agency afforded by the arrangement, so retreating once again into his preferred discursive position - this correlated directly with his withdrawal from the co-inquiry process (see p 992).

*Existential*

During our co-inquiry discussion on Maslow's schema, Dan was surprised that I derived no self fulfillment from my patients' recovery as a therapist. I deliberately clarified my position on the matter as a *discursive* therapist by pointing out that since recovery was ultimately the patient's personal choice, I was not in a position to derive self-fulfillment as a discursive therapist - I simply facilitated a process; any recovery was entirely the patient's responsibility. Any expectation on my part would limit their personal freedom and also delimited the discourses within which they might chose to position themselves; my role as therapist was simply to assist patients in sharpening their sense of

personal agency with regards to any life problems as understood by them. Through congruent self-disclosure, I was able to position Dan within an alternative story-line to the one he had assumed for the helping professions. In this way, it was possible to effectively highlight the *quintessential* contribution of personal choice and responsibility to the operation of optimal personal agency in Dan's world (see p 918-9 and 928-931), for example, in connection with his substance abuse (see p 921).

Given the overarching co-inquiry research metaphor, I was in a position to use self-disclosure to the fullest advantage in the therapeutic positioning and therefore disclosed any discursive material which might have assisted Dan in reaching his therapeutic goals. This was especially useful in connection with 'normalizing' since I presented a role model for the so-called 'normal' person; I therefore disclosed that I too felt anxious, unsure, depressed etc. about certain topics, some of which I discussed in some detail as illustrative points (see p 808-810). Although I am not sure what Dan knew about my personal life given our initial informal meeting outside of the therapeutic context and the social network context of its occurrence, I managed to integrate this informal meeting into the therapeutic positioning after Dan made reference to it during the co-inquiry process (see 'systems-theoretical' below).

*Client-centered*

I attempted to remain 'congruent' about my thoughts and feelings where possible during the co-inquiry (see p 643). I also attempted to reflect Dan's discursive world through non-verbal behaviors, such as offering him a soft-drink when his mouth was dehydrated from the side affects of psychiatric medication and then sipping a drink of my own during the session (see p 659). Finally, while my approach was clearly confrontational (as requested by Dan), I nevertheless attempted to model unconditional positive regard towards *Dan* (see p 802) despite my personal moral perspective on his activities (e.g., cruising (see p 748-9)), and rather only proscribed specific behaviors, story-lines or interpersonal positionings that might interfere with Dan's development of personal agency. I attempted to keep my moral position on matters private at times, therefore, and rather only attended to the structural relation of his story-lines in terms of reaching his therapeutic goals.

By using the client-centered techniques together with more directive and confrontational approaches, it was possible to strengthen Dan's sense of self esteem, preserve therapeutic neutrality yet simultaneously confront Dan on his self destructive discursive metaphors and their operation. While a non-directive approach forced Dan to take responsibility for any self improvement initiative, thereby moving into personal agency, it is however important to point out that in Dan's case, any *unitary* unconditional positive regard excluding confrontational and restructuring elements in the therapeutic

positioning strategy would have resulted in the same redundant therapeutic positioning afforded by the other schools of thought already considered in this chapter - once again this is largely explained by the *social* nature of Dan's problems. That is, Dan would not have been able to find his own solutions to his difficulties if typical non-directive therapeutic principles were applied over any extended period - unconscious structural anomalies needed to be explicated, challenged and reformulated in order to effect any palpable therapeutic change at the discursive level. These arguments are supported by the fact that Harry's persistent positive regard towards Dan had achieved little in the way of social adjustment over twenty-five years (see p 778). A derivative of this argument also therefore suggests that the life-story research process alone could not have effected satisfactory change either since it relies principally on reflective listening on the part of the researcher. However, client-centered techniques and principles were indeed extremely useful and necessary components within the overall therapeutic positioning strategy.

**Systems-theoretical**

Although therapeutic positioning occurred primarily within an individual therapeutic context with Dan, it was nevertheless useful to apply systems-theoretical techniques and principles during the intervention in a number of different ways in order to facilitate Dan's progressive development of personal agency:

*Strategic*

While my initial informal meeting with Dan involved my demonstrating paradoxical discursive mechanisms in relation to his life problems, given the specific context and circumstances (see Chapter 6 and p 594-5), I used any other paradoxical techniques very sparingly during the co-inquiry, for example, as a reflective challenge to Dan to motivate him into establishing another relationship other than with Harry (see p 908-9), and where Dan's behavior was obviously interpersonally manipulative, for instance, I suggested that he stay 'deaf' after he announced his 'deafness' (see p 738).

While these strategic techniques were very useful in shifting Dan closer to his therapeutic goals, in retrospect I have certain misgivings about their application more generally as discursive reconstruction tools in *Dan's case*. That is, in an effort to assist Dan in developing effective personal agency, it seems that any overuse or central positioning of these methods during reconstruction work would remove the locus of control from Dan - ultimately he alone was responsible for any salutary changes in his life adjustment. Indeed it seems unfortunate to me that in our first meeting a 'competitive' spirit set the tone for our mutual interaction during the co-inquiry process. This was only made clear to me in concluding the project when Dan pointed out in the closing minutes of our

telephone conversation that he had not always been congruent about the substances he was taking during the therapeutic encounter (see p 993). From this discursive interaction, it therefore seemed to me that Dan understood our therapeutic interaction to be 'competitive'; that is, I was trying to change him using devious, strategic methods and he, in turn, was making every effort to outfox me. This explanation is further supported by the fact that midway through the co-inquiry process I noticed that my attempts at mediating pragmatism (see 'cognitive-behavioral' above) were misinterpreted by Dan as strategic interventions; that is, Dan brought up the subject of our first meeting in relation to his misconceptions of my therapeutic positioning during the co-inquiry process. During the co-inquiry process and given the therapeutic moment, I therefore deliberately pointed out the motivation for the exercise at the time of our initial meeting; that is, to illustrate how opposed Dan was to finding any solution to his life problems, which also helped orientate him to my therapeutic intention behind the immediate exercise at hand (see p 819-20). This clearly was insufficiently convincing for Dan. Had I been more aware of the extent of this 'unsaid', submerged story-line during the process, I certainly would have confronted Dan more emphatically on the matter by pointing out his misunderstanding in context of his own story-lines, our initial meeting, and the true intentions of the co-inquiry exercise from my point of view - this *might* have been more convincing.

*Structural*

Two interpersonal systems (collective level) in Dan's world required restructuring during discursive reconstruction work with him at the individual level; namely, Dan's relationship with Harry and the psychiatric half-way home community. In the former, it seemed necessary to assist Dan's emotional and material separation from Harry, since Harry's 'rescuing at all costs' story-line threatened to maintain Dan's life endangering overdosing displays (see 'clinical formulation' above) and his discursive ineptitude given his skills deficit. Indeed *Dan* referred to their 'co-dependency' (see p 974) independent of my using this particular phrase and also described Harry as follows:

> *Dan: ... in the past it has been a pattern of people so-called taking charge of me. I mean Harry might be an example there, that is a very complicated case.* (p 679)

On pointing out to Harry that Dan's lack of personal agency skills was partly due to his rescuing behavior - like substance dependency and abuse, Harry removed important lessons for Dan's personal growth. Harry said that he had never considered matters in this light before (see p 989-90). The final session was the only dyadic level intervention within the co-inquiry process and this session together with Harry's independent interview comprised the sum therapeutic contact with Harry, apart from conversation on the telephone. It seems, therefore, that further dyadic work would have been useful for ensuring that Dan maintained a level of independence so to follow through his outlined plans. However, their return to living together as flat mates meant that they had both chosen to break their

contract for shared living arrangements between the psychiatric half-way home and Harry's new flat (see 'Maslow' above) - this meant that Dan now had the choice to use the reprieve productively or delay his personal agency skills development still further until he simply had no further option open to him (see p 990). It was my contention, therefore, that Dan needed to be deliberately positioned within a 'tough-love' story-line, where he was forced to adjust using his own discursive skills; indeed it seemed that Dan learned best from life's consequences ('cognitive-behavioral' principle) and both Dan and Harry were fully aware of this discursive reality (see p 991) - Harry's role in Dan's life was a significant interference in that natural process.

I never interfaced directly with any members of the psychiatric half-way home although I was informed through Dan's conversation of his discursive positioning within the community. His successful discursive adjustment at the home was an important aspect of his intermediate self development process; that is, 'refining his psychiatric career'. I therefore needed to assist his adjustment at the home through my therapeutic positioning. Furthermore, Dan indicated that it was indeed possible for him to adjust more successfully there and even argued its preference over the course of the research (see p 992). I therefore attempted to reinforce his adjustment by not only advocating his shared living arrangements between the Enochs and Harry, as already discussed, but by also making suggestions that he engage in alternative speech-acts and consider alternative story-lines and positionings within the home; over the course of the research period, his adjustment improved significantly within this context (see p 983-991). I made many suggestions through the co-inquiry process, for example, I suggested that Dan chose to experience his housemates as colorful members of a drama class, not a 'dysfunctional menagerie' (see p 983). I also gave Dan a copy of 'I &You messages' and we rehearsed these briefly in relation to Mrs Enoch (see p 733). And, finally, we considered how his various needs could be met through living at the psychiatric home through extended discussions pertaining to Maslow's Hierarchy of Needs (see 'humanistic' above).

*Milanese*

Reframing techniques were used extensively throughout the therapeutic positioning process in order to assist 'normalization' (see 'RET' and 'psychiatric' above) as well as the development of coping skills and personal agency more generally - some examples include:

- by reframing Dan's social identity position positively, as a moral 'career', I was able to position Dan within an 'adjusted' story-line albeit that he was a certified mental patient. This included a host of positive reframes, for example, I reframed state funded psychiatric medication as Dan's 'expense account', and even challenged him by suggesting that his addiction required the career in order to maintain the 'fringe benefits' (see p 959-60); when Dan talked about his symptom fabrication and presentation to psychiatrists, I reframed this as being similar to selecting

biographical material for 'curriculum vitae' (CV) presentation during a job interview (see p 855); and, finally, I framed his defying diagnostic classification as 'promotion' in his 'career', given both the changed social welfare policies and the very special place in the psychiatric community that this situation created for him; that is, Dan simply could not be dismissed through disqualification as a Borderline Personality Disorder if the authorities were unsure how to classify his 'illness' to which his chronic psychiatric history clearly testified (see p 874).

- I used humor throughout the co-inquiry both as a general joining strategy since Dan actively voiced his enjoyment of a jocular atmosphere during the therapeutic process (see p 711-2), and as a discursive means for reframing anxiety responses; for example, when Dan was withdrawing from psychiatric medication during the co-inquiry, his deranged thoughts included blasphemous protestations to the theme of a childhood ditty - rather than collude with his righteous indignation at his sacrilegious ways, which of course confirmed for Dan his insanity, by simply laughing (speech-act), I highlighted the fact that he was withdrawing from psychoactive substances given the discursive context of our preceding discussion, nothing more, which he then spontaneously acknowledged (see p 831-2). The reframe was one of many pertaining to Dan's guilt in relation to religious themes.
- negative reframing was used to perturb Dan into formulating alternative discursive notions where a story-line or position threatened to maintain Dan's psychiatric status quo; for example, Dan presented his 'pain and suffering' on countless occasions during the co-inquiry, usually in very abstracted, philosophical ways divorced from any action or personal responsibility. Dan's 'pain and suffering' was indeed the central discursive pivot about which he justified his substance abuse, as 'relief for his pain'. By negatively reframing Dan's self location within the 'inevitable pain and suffering' story-line with the 'fallen creative genius' story-line (see 'clinical formulation' above), I was able to point out to Dan how his discursive assumptions, his personal identity and his social positioning were all mutual contributions to his need for 'pain and suffering'; these were not inevitable and beyond his control. By implication, therefore, he was capable of dispensing with the 'fallen creative genius' story-line and, of course, his 'pain and suffering', by exercising his personal agency and finding other ways of meeting his social and personal identity needs. Similarly, Dan framed his overdosing antics as 'coping with pain and suffering' whereas I negatively reframed this position by pointing out that overdosing was the only real interpersonal signal to the psychiatric community and to Harry that he was sufficiently dysfunctional to warrant both a disability grant and Harry's emotional and material support; rather than emotional relief, overdosing simply maintained his psychiatric status quo which, in turn, required 'pain and suffering' for membership - in this sense, 'pain and suffering' were inevitable (see 973-4).

*Eco-systemic*

At both the macro- and micro-systemic levels within Dan's discursive eco-system, restructuring had taken place; that is, the changing welfare policies within the South African socio-political macro-system initiated a crisis for Dan as an individual nested within discursive superstructures and, similarly, his accommodation arrangements with Harry at the micro-systemic level were uncertain. For the first time in Dan's experience, his psychiatric moral career was in jeopardy and would be tenuous for evermore. Dan understood the crisis to involve a 'cross-roads or choice' given Greek etymological roots of the word 'crisis' (see p 900). I wholeheartedly supported this framing of the eco-systemic changes in Dan's discursive world, and indeed intensified this framing by suggesting that any life adjustment crisis was a 'gift' since it inevitably forced the development of personal agency given the challenges posed by new discursive areas (see p 954). I attempted therefore to assist his overall life adjustment by pointing out the personal growth potentials within his new eco-system and providing specific directives on living arrangements and suggestions for optimal eco-systemic adjustment both in the short and long term (see 'structural' above).

**Narrative**

I placed personal agency at the epicenter of the therapeutic positioning work with Dan. Dan's crisis can be understood to have existed as a function of a *lack* of personal agency in relation to the *new* discourses comprising his world; that is, although Dan had been able to meet many of his social and personal identity needs in the past through his psychiatric patient role, changing social discourses had *forced* Dan to reconsider his social positioning - his relative lack of personal agency ultimately restricted his life adjustment under the new discursive circumstances. In short, Dan was not able to live the kind of lifestyle which he found most comfortable and to which he was most adjusted in his psychiatric role; that is, living with Harry and contributing his disability allowance towards their household expenses.

I therefore explicitly mediated notions of personal agency at both a theoretical level (exploring the concept) (see p 678) and practically (through skills and awareness enhancement, therapeutic positioning etc.) in order to assist Dan in re-authoring certain critical aspects of his life story. As a super-ordinate strategy, therefore, I attempted to trawl Dan's psychiatric positioning for any sign of personal agency, thereby using Dan's life story as a metaphor through which we could explicate the meta-principles associated with *optimal* articulation of personal agency; that is, where Dan's self reported expectations of his life adjustment in terms of his social and personal identity were congruent with his perceived actualization of these discursive assumptions. During the course of the co-inquiry, I therefore reframed much of Dan's psychiatric positioning activity as instances of *non-optimal* personal agency, but agency nevertheless (see p 887-9), thereby explicating the meta-

principles involved in agential acts on the part of any individual within any given social discourse. Dan reported that he found the 'personal agency' (he called it 'self agency', I didn't correct him) concept very useful and towards the close of the co-inquiry, he was using it spontaneously as a general heuristic (see p 830).

The following therapeutic activities are good examples of my mediation of agency and related notions during the co-inquiry process, although many more instances of this sort can be found in the individual unit transcripts:

- Dan's limited accommodation and employment options, his forced residence at the psychiatric half-way home despite his antipathy were all reframed as indications of a lack of personal agency, or *non-agency* (see p 701); Dan's inability to control these aspects severely hampered the actualization of his own life adjustment expectations (see p 685);
- Dan's suicide attempt was reframed as *non-optimal agency* since he was trying to gain control over the horrors of benzodiazepan withdrawal (see p 707);
- similarly, Dan's use of psychiatric medication to cope with his emotional 'pain' as well as the 'pain' itself were explored for their *agential qualities*; that is, Dan's 'pain' was useful and indeed necessary for his 'patient' positioning (see p 696-670), while his overdosing displays served an important signaling function for convincing performance of the psychiatric patient role (see 'Milanese' above);
- I pointed out that Dan's creation of a substitute father-figure in Harry to replace his experienced paternal absence was an instance of *optimal* personal agency (see p 725);
- so too were aggressive feelings in dependent relationships non-optimal since they indicated Dan's search for autonomy (see p 728-9) as was his transient 'deafness' when feeling socially overwhelmed and helpless (see p 738);
- Dan's beliefs in connection with 'managing the future' as deconstructed in the rep-grid work were provided as examples of discursive assumptions lacking personal agency (non-agency) since Dan's active positioning in any future was not catered for within their constructs (see p 741-2);
- pointing out that Dan's self relocation into the obverse pole of his father's 'achievement at all costs' story-line was an act of agency given his associations (see 'clinical formulation' above);
- demonstrating that his substance use/abuse induced blackouts were instances of non-agency since he was totally out of control and simply created more adjustment difficulties for himself, as would be any involuntary death by substance abuse (see p 887-8);
- highlighting that ultimately substance abuse and dependency were his greatest stumbling blocks towards his optimal development of personal agency (see p 952-3);

- I supported Dan when he took the initiative and stopped smoking cigarettes as a deliberate act of personal agency in order to save money and to enhance his sense of self-empowerment given that even people such as Freud, Jung and his psychiatrist were not able to kick the habit (see p 785-6).

**Therapeutic Deconstruction Analysis**

Part of assisting Dan in re-authoring his life story involved deconstructing certain cultural story-lines and positions. For example, together we deconstructed different cultural discourses on aggression:

- Dan experienced enormous anger towards God (Christian) for his perceived injustice in cursing him with debilitating 'mental illness' and not caring sufficiently for Dan (see p 731-2), yet he also experienced remorse and guilt at his blasphemy. As part of the emotionological reconstruction work around aggression more generally, I therefore perturbed Dan into considering other cultural assumptions around aggression and spirituality. Specifically, we discussed the goddess, Kali, in this regard since as a central figure in Eastern religions, her symbolic representation indicates the underlying cultural emotionology integrating destruction (anger, aggression etc.) and creation (love, nurturance etc.) within the same discursive formulation, and does not split them as occurs in the Christian emotionology, for example (see p 650, 730-2).
- we also deconstructed different cultural emotionologies in relation to family life and aggression, for example, Italian and Afrikaaner (see p 730-1) in order to highlight the range of discursive constructs available to Dan in his re-authoring efforts.

## CONCLUSION

I found the co-inquiry project extremely interesting from a therapeutic point of view and, on the whole, the therapeutic positioning process adopted appears to have been useful to Dan. Please refer to the following therapeutic evaluation comments: 1) Dan and Harry (final session): p 980-991; Harry alone: p 767-8; and, Dan's spontaneous evaluations: p 716, 825 and 992-3.

Dan clearly still had a great deal to work through in the supportive long term therapy he was considering at termination (see Chapter 6 and p 992) and in life generally, with or without the support of therapeutic assistance. I however do believe that the co-inquiry project sowed a few crucial 'discursive seeds' at a time of crisis in Dan's life; this tumultuous time provided a fecund 'discursive field' through which these seeds might germinate, grow and finally bare fruit in time to come. Of course, this is all up to Dan, ultimately.

## Chapter 10

# Summary Conclusion: Critical Review

A critical reading of the discursive clinical psychology project suggests that certain meta-theoretical contentions necessitate further philosophical consideration and explication in order to fulfill the requirements of scientific rigor for this doctoral thesis and include the following central questions:

1. Is discursive clinical psychology yet another form of therapeutic *eclecticism*? How does it differ from other forms of eclecticism? Why is its therapeutic value superior to other forms of eclecticism?
2. Are the meta-theoretical claims of ubiquitous *therapeutic inclusiveness* and relevancy philosophically justifiable and theoretically sustainable? Indeed are the meta-theoretical arguments for therapeutic inclusiveness posited in this thesis a *simplistic* reading of the theoretical complexity implicit within psychotherapeutic schools of thought?
3. Is the discursive clinical psychology project sufficiently *reflexive* in accounting for its own discursive position? Indeed does a Clinical Psychology position on Harré's Discursive Psychology contradict certain central Social Constructionist tenets? Are these tenets intrinsically incommensurate with Clinical Psychology talk related to 'patients', 'psychopathology', taxonomic 'diagnosis' and 'treatment', for example?
4. What is the way forward for the discursive clinical psychology project? What future studies should be undertaken in order to rally support for its conventionalization as a therapeutic position? Which points of *contention* need further theoretical consideration, elaboration and research focus? Which points of *interest* may be further developed in light of the case study analysis? What are the *limitations* of this particular doctoral research endeavor into a possible discursive clinical psychology?

These questions will be systematically addressed during the course of this concluding chapter, where reference is made to many divergent concerns raised throughout the preceding chapters.

## CENTRAL CONTENTIONS

### Is the discursive clinical psychology project yet another form of therapeutic 'eclecticism'?

Carson, Butcher and Mineka (2000) maintain that when asked, most contemporary psychotherapists would describe themselves as 'eclectic' in their meta-theoretical orientation, yet the very meaning of this categorical notion diverges as a function of any chosen discursive field. Carson et al. maintain that indeed

*"(eclecticism) appears to be a movement whose time has come ...since no single therapy has proved to be effective at all times in all clinical situations, it seems reasonable to many to attempt to use the best components among them, often in combination. This has been done in a number of ways."* (p 676)

The authors identify the following theoretical sub-categories for 'eclecticism': 'multimodal therapy'; 'therapeutic commonality'; 'technical eclecticism'; 'the biopsychosocial unified approach'; 'theoretical deadlock' and, the 'middle ground approach'.

In *multimodal therapy* (Lazarus, 1997, 1985, 1981), therapists are encouraged to explore differing ways of approaching clinical problems given the conflation of the discursive boundaries that once informed opposition therapeutic schools, such as early behaviorism and cognitive therapy, into a unified focus on treating each individual case as is most appropriate. The inclusive range extends to combine individual and family systems therapy (e.g., Feldman, 1992; Wachtel, E., 1994) and combined biological and psychosocial approaches (e.g., Feldman & Feldman, 1997; Klerman, Weissman, Markowitz, Glick, Wilner, Mason & Shear, 1994; Pinsof, 1995), for example, but is unbounded in possible range (Gold & Striker, 1993; Goldfried, Greenberg & Marmar (1990); Norcross & Goldfried, (1992); Wachtel, 1997).

Another combination method is an attempt to identify the *common threads* shared by all or most of the different psychotherapeutic schools of thought, for example, empathetic listening and nonjudgmental acceptance. Carson et al. report that integrationists have met with little success in their investigations.

Another possibility lies in a form of *technical eclecticism* guided by principles of therapeutic usefulness (P. Wachtel, 1997, 1993, 1987, 1977), a 'whatever works' approach despite being theoretical irreconcilable. However, the clinical formulation, diagnosis and treatment possibilities are far from clear especially since each school of therapy can have *radically* varying conceptions, often incommensurate, for example, individualist and systems-theoretical approaches. The resulting therapeutic effort is therefore a form of trial and error problem solving on the part of the therapist and is not guided by any central therapeutic principles; essentially, any systematic therapeutic intervention would be arbitrary since a consistent, unified model of the human being, life problems and the path to readjustment, would amount to a logical impossibility.

Similarly various attempts at *unified biopsychosocial models* (e.g., Carson, Butcher & Mineka, 2000; DSM III, III-R, IV publications) try to integrate primary dimensions to explain human adjustment

anomalies; that is, the influence of 'biological', 'psychosocial' and 'sociocultural' levels - yet each level requires a specific reading, the texts of which may be mutually antithetical. For example, reading so-called 'genetic loading' (biological level) for psychopathology must involve sociocultural assumptions in the first instance as discussed in Chapter 1. Of course, the obvious question (Whose socioculture?) points towards hegemony as ultimately determining what 'genetic loading' actually means. So too for notions such as 'dysfunctional family relations', 'peer group pressure' etc., all require a textual reading of sorts, while any identification of broad 'sociocultural influences' are difficult to isolate, in the first instance, and are also easily contaminated by the discursive readings and projections of the observers/judges/empirical processes during 'sociocultural influences' readings. In the unified biopsychosocial model nothing other than a descriptive commentary of various texts is possible; any psychotherapeutic intervention is also essentially arbitrary, therefore. Clinicians are therefore guided simply by their 'commonsense', so to speak, since no professional clinical formulation is indeed ultimately possible from this so-called 'unified' position. Consequently these integration projects are also philosophically unsound since no overarching reading has been properly formulated in the biopsychosocial approach. For example, the later models of the DSM IV manuals sport elaborate embellishments supporting the integration of social factors in efforts to improve DSM diagnostic validity yet still persists in perpetuating ethnocentric notions given the Positivist meta-theoretical superstructure. These conceptual problems all emerge as a function of first premise (meta-theoretical) anomalies at the philosophical level.

Technical eclecticism and the unified biopsychosocial model cannot be accounted for meta-theoretically which leaves three possible conceptual resolution possibilities:

- declaring the conceptual terrain involving any integration efforts as invalid on the grounds of post-modernist theoretical incommensurability. This option, however, contradicts intuitive a priori appraisal of Empirical observation supporting the efficacy of a 'working eclecticism', of *some* (yet to be identified) sorts, as quoted by Carson et al., and, furthermore, by the authors' reference to the fact of numerical dominance of 'eclectic' therapeutic choices over purist schools amongst therapists, as discussed above.

- developing a 'middle ground' where a therapist chooses one personally congruent therapeutic school which then informs the clinical formulation pivot in a consistent and philosophically accountable fashion. Therapeutic efforts are, however, simultaneously attuned to the idiosyncrasies of each case so to redress the natural limitations of the principal school for effecting the most useful intervention strategies for different cases. Of course, the meta-theoretical problems discussed earlier in relation to 'working eclecticism' can be leveled at 'middle ground'

approaches as well since any idiosyncratic accommodation automatically deranges any possible theoretical consistency.

- formulating an overarching meta-theory for the integration of all the various therapeutic schools; that is, psychiatric, psychoanalytic, cognitive-behavioral, humanistic, systems-theoretical, narrative and therapeutic deconstruction analysis; in this regard, Carson et al. believe that if this project were ever to be realized; that is

  *"If a grand, overriding theory of psychotherapy does emerge from the efforts of the psychotherapy intergrationists or from other sources, our guess is that it will be accompanied by dramatic new insights about the nature of mental disorders. At present, we still know too little that is ironclad about the "inner workings" of both disorder and its treatment, which is what permits radically different conceptions to thrive side-by-side".* (p 696)

It has therefore been posited in this doctoral thesis, that indeed discursive clinical psychology is not simply another 'eclecticism'. That is, by placing Discursive Psychology epistemology as the meta-theoretical vehicle for Clinical Psychology (tenor), new emergent epistemic meanings are possible through metaphorical interanimations between tenor and vehicle, in relation to the typical activities associated with clinical psychotherapy, such as diagnosis, clinical formulation and treatment intervention. *Discursive* clinical psychology therefore informs all therapeutic endeavor as discursive positioning through speech-acts within possible story-lines, including mainstream and more radical psychotherapeutic approaches, as these have evolved through phylogenetic historical processes: the institution of Clinical Psychology is understood to be a Western socio-cultural artifact, in Vygotsky's sense. This discursive artifact has emerged through progressive discursive activity around developing rhetorical devices for effecting therapeutic positioning. These rhetorical devices have been developed through concerted efforts at assisting people to improved life adjustment, given various psychological problems in various forms, as experienced by individuals themselves or significant others in their social world. The efforts made by therapists to both understand and improve these circumstances for the benefit of those choosing to consult expert advice on their life difficulties, therefore amounts to Empirical research into the processes informing healthful psychological change. As rhetorical devices, it is argued that any therapeutic activity, no matter which therapeutic school marks its origin, attempts to persuade those in therapy through speech-acts within story-lines towards healthful change in some form or another; as such, principles, techniques and strategies from various schools of therapy might be coordinated into a working whole to assist in improved psychological adjustment *if* an inclusive meta-theory can be formulated yoking together all the primary philosophical tenets informing Positivist and Social Constructionist theoretical positions which underpin the discursive fabric of the various schools mentioned earlier. It is posited that indeed Rom Harré's meta-theory for

(social) psychology as outlined in Chapters 2, 3 and 4, as well as the discursive clinical model adapted from interanimations with Discursive Psychology meta-theory in Chapter 5, 6, 7, 8 and 9, provides an inclusive, consistent and integrated meta-theory for conceptualizing the interactive working of biological, social, individual, intrapsychic, interpersonal as well as socio-cultural dimensions. These primary domains which must *necessarily* inform any meta-theoretical starting point for theoreticians attempting to make sense of the activities typically involved in psychotherapy. We turn now to a critical review of these assertions in light of the discursive clinical psychology project before moving on to further discussion of the other critical concerns outlined earlier.

**Is a discursive clinical psychology reading of psychotherapy simplistic?**

Discursive clinical psychology formulations for resolving the meta-theoretical schisms and shortfalls of Clinical Psychology might be criticized as being simplistic; that is, can over one century's worth of investigative investment into the activity of psychotherapy and the social institution of Clinical Psychology, simply be reduced to rhetorical speech-acts persuading patients towards healthful change between psychotherapist/s and patient/s? Is it philosophically valid to simply dismiss the theoretical edifices that comprise each therapeutic school's position and adopt a discursive clinical psychology position through a loose synthesis of various therapeutic positions?

In order to address these contentions, it seems useful to extend the mathematical metaphor already discussed at the beginning of Chapter 5 to highlight the conceptual operation of the arguments posited in this thesis. That is, Discursive Psychology's interanimations with Clinical Psychology might be equated with Albert Einstein's insertion of the dimension of 'time' into Newtonian formulations (equations) pertaining to the social institution of 'Physics' as this phylogenetic artifact existed at the time of his critical insight. Similarly, by understanding *all* therapeutic interaction as speech-act contingent, by inserting 'discourse' into the theoretical formulations from Positivist and Social Constructionist therapeutic schools, it is indeed possible to reconstitute Clinical Psychology in terms of Discursive Psychology. It is posited that Discursive Psychology provides an inclusive meta-theory explaining any social activity in the human universe, and therefore can subsume the social institution of Clinical Psychology within its meta-theoretical formulations - hence, the hybrid meta-theory - 'discursive clinical psychology'.

Clinical Psychology, on the other hand, has a set of mandatory discursive constructs which constrain the registered clinician to operate within a circumscribed discursive field, as might any social institution, in order to perform specified clinical activities such as assessment, diagnosis, and treatment intervention (see Chapter 5). The registered clinician is not in a legal position to apply novel therapeutic punctuation for the alleviation of life adjustment problems and is forced to work

creatively within these restrictions. Therefore, by inserting 'discourse' into the broad phylogenetic artifact of Clinical Psychology, not only is it possible to highlight the one *necessary* feature for all possible therapeutic interchange, namely, 'discursive interaction between patient and therapist' which until the arrival of recent narrative therapeutic principles, techniques and strategies, had been given only minimal attention during therapeutic activity, but also liberates all possible discursive resources which have been developed from *both* Discursive and Clinical Psychology over time. The former pertains to the rich research methodology and method developed for philosophically valid empirical research into social worlds generally, which can be meaningfully adapted for Clinical Psychology activity, as can the primary premises and empirical scheme developed in Harré's Discursive Psychology more generally. The latter involves techniques, strategies and principles from an assortment of psychotherapeutic developments as these have been refined over the last century, in order to best address the activities ordinarily involved in psychotherapy. This is possible since all psychotherapeutic theories have attempted to address the same question - how might psychotherapy be improved in order to be more effective for patients? Each school of thought appears to have involved genuine efforts to redress the shortfalls of preceding theoretical traditions in Clinical Psychology, and as such, the Clinical Psychology phylogenetic artifact provides another rich discursive heritage upon which an *optimally* effective psychotherapeutic school might be developed. Therefore, by placing the *ultimate* vehicle of all possible theories; that is, 'discourse' per se, at the center of therapeutic activity, that is, *'therapeutic discourse'*, it is possible to *re-formulate* therapeutic discourse and the entire institution of Clinical Psychology in terms of the central ideas comprising Harré's Discursive Psychology. This conceptual permutation allows for useful synthesis of therapeutic principles, techniques and strategies from all the therapeutic schools discussed in Chapter 1, while also liberating all the Discursive Psychology research methodology and method discussed in Chapter 4 for application during therapeutic discourse. Harré's Discursive Psychology provides an overarching meta-theory, it is suggested, which facilitates useful integration of the primary dimensions underpinning therapeutic discourse of any sort; that is, biological and social aspects, interpersonal and intrapsychic dimensions, cognition and affectivity which must necessarily comprise any discursive field for any meta-theory of psychotherapy given typical Clinical Psychology activities such as family, couples and/or individual therapy.

Discursive Psychology is therefore not simplistic, it is argued, since this integrative project liberates the speech-acts of different schools of psychotherapy as 'therapeutic tools', while Discursive Psychology provides the meta-theoretical substratum or 'therapeutic toolkit' through which regular Clinical Psychology activities might be properly conducted according to a professional schema. The practical repercussions that this integrative meta-theoretical project might generate for *optimal therapeutic discourse* might be equated with the revolutionary insights Einstein's insertion of the

'time' dimension into Newtonian assertions facilitated for the theoretical discipline of Physics, and related applications in engineering and surgery, for example. Indeed, like 'discourse', 'time' was a ubiquitous, opaque first principle in Newton's formulations and therefore remained implicit and non-operationalized until Einstein's efforts clarified the operation of 'time' within the phylogenetic institution of Physics, thereby re-organizing our understanding of the physical universe. Similarly, by clarifying the role of 'discourse' in psychotherapy, Harré has assisted in re-organizing our understanding of the social universe, and in its wake, our understanding of contrived social change, of which the social institution of Clinical Psychology is a part, as a form of social (discursive) engineering.

**Is the discursive clinical psychology project sufficiently reflexive in accounting for its own discursive position?**

Words such as 'patient', 'psychopathology, 'diagnosis' and 'treatment' clearly refer to traditional psychotherapy allied with the psychiatric profession and have been used liberally throughout this discursive clinical psychology project discussion. However, can a medical metaphor be sustained within the tenets of Discursive Psychology, which understands the institution of Clinical Psychology as one of many possible social constructions in the human world? Would it not be more useful to choose words such as 'client' instead of 'patient', 'facilitator' rather than 'psychotherapist', 'negotiated diagnosis' between client and facilitator rather than DSM IV taxonomy, and 'personal growth program' rather than 'intervention' or 'treatment' - in short, is Discursive Psychology indeed reconcilable with Clinical Psychology? Is this not an instance of theoretical 'incommensurability' that requires a more rigorous reflexive analysis?

In addressing this possible criticism it must be remembered that Harré's meta-theoretical formulation contains both Positivist and Social Constructionist theoretical assumptions in that Realist and Empirical elements are counterpoised with Social Constructionism; the universal is placed together with the relative, and in so doing, it is possible to navigate psychological space from fixed positions within a relative discursive universe. As such, the psychiatric Clinical Psychology position is but one of a multitude of possible story-lines which may be taken up by the discursive clinical psychologist, as might the 'humanist-phenomenologic' position focusing on personal 'growth', for example, or more radical approaches dictating 'negotiated diagnosis' (Gergen, Hoffman & Anderson, 1996). The discursive clinical psychologist is *not limited by any therapeutic discourse* except those outlined in Harré's Discursive Psychology (meta-theory) or those mandated by clinical regulatory authority, as these change over time.

Whether traditional or radical, all psychotherapeutic schools provide useful speech-acts for any possible therapeutic positioning, yet no one position can account for all possible therapeutic acts since by definition, each school evolved in an attempt to redress the problems of those preceding its phylogenetic development. By working eclectically with methods from different schools of psychotherapy and with the research methodology and empirical scheme formulated for Discursive Psychology, it is possible to optimize therapeutic positioning by adopting a set of speech-acts which most affords the attainment of therapeutic goals as defined by therapeutic subjects' themselves. For example, a psychiatric position was useful for therapeutic positioning with the father of the child discussed in the collective unit intervention (see Chapter 7): although the child's mother had attempted to address both her son's and her own unhappiness on other occasions, the father had been uncooperative until his son's difficulties had been suitably 'pathologized' and deliberately linked to familial interaction, which seemed to assist in motivating him into generating solutions to their son's 'illness' and changing family communication patterns as these were demonstrated to be maintaining his son's psychopathology. On the other hand, in both the dyadic (Chapter 8) and individual (Chapter 9) unit intervention, any psychiatric positioning did not seem especially useful for effecting salutary therapeutic change as conceptualized by the 'client', since in both cases the 'patient role' and other medical metaphors had been demonstrated to have been ineffective in bringing about an improvement in the clinical picture as understood by the therapeutic subjects themselves. Finally, while narrative therapy certainly provides essential theoretical wherewithal for effecting discursive clinical psychology in day to day practice, the position is once again limited by its radical allegiance to Social Constructionism, and therefore is not sufficiently inclusive to assimilate Positivist schools of psychotherapy such as the psychiatric position to which it is indirectly allied as a form of psychotherapy. Restoring personal agency to the family members of the collective unit, for example, might have been compromised if a psychiatric position had been ignored in favor of purist narrative therapy interventions.

It might, however, still be argued that these assertions nevertheless beg the question of a *unified* Clinical Psychology; that is, discursive clinical psychology still relies on the therapist as agent of change within the psychotherapeutic context to make decisions whether to use one or another school of psychotherapy during therapeutic positioning. Does this mean that in effect discursive clinical psychology is yet another form of 'working eclecticism' simply cloaked as meta-theoretically valid yet practically indistinguishable from meta-theoretically invalid forms of eclectic therapy? Is this the case since any therapeutic positioning choices made are essentially arbitrary as they are directed by the therapist within a vague overarching theory suggesting the creation of 'optimal personal agency as understood by the therapeutic subject' and nothing more? In order to address this possible criticism it is essential to point out that discursive clinical psychology relies on metaphorical

interanimations in both directions; that is, from Clinical *and* Discursive Psychology positions. For example, DSM taxonomy from Clinical Psychology may be borrowed to anchor therapeutic efforts from a clinical position. As a phylogenetic artifact, the DSM taxonomy therefore provides not only the current mandatory discursive field for Clinical Psychology, which deliberately positions 'therapists' and 'patients' into a forced medical metaphor, but can also provide useful therapeutic vocabulary for therapists working with other practitioners, as well as a possible biopsychosocial model which reflects the broad philosophical dimensions of Discursive Psychology. Consequently the discursive clinical psychologist must attempt to use this forced positioning in some creative manner and draw upon the strengths of the medical model while redressing any therapeutic weaknesses; in this manner, the discursive therapist is able to articulate his personal agency with regards to his social identity as a registered psychotherapeutic clinician, yet attempt to find an optimal therapeutic position for the wellbeing of his therapeutic subject. For example, Chapter 8 demonstrates how a fair DSM IV diagnosis might be created for people in couples therapy, while Chapter 9 demonstrates why in the individual unit case study it was necessary to avoid *public* therapeutic discourse supporting DSM categorization with the therapeutic subject. On the other hand, a DSM IV diagnosis still provided useful 'biopsychosocial' descriptions of the subject's psychological position while also formulating a clear clinical picture upon which clinical directives such as detoxification procedures could be mobilized.

It is furthermore, important to point out that any interanimations between the two primary discursive fields still need to be fully articulated through their natural evolution as 'interanimated' phylogenetic story-lines. For example, the discursive clinical psychology project certainly relies on some form of taxonomy for ordering clinical diagnosis, for example, yet the DSM taxonomy is clearly limited, as is any clinical perspective. The discursive clinical psychologist would therefore support any improvement, refinement or replacement of the DSM taxonomy which supported Discursive Psychology principles. For example, the Axis II diagnoses; that is, 'Personality Disorders', could be reformulated in order to better achieve a useful taxonomy of sorts, as the individual unit case study in Chapter 9 clearly demonstrates. Indeed the new relational diagnoses provide useful and discursively congruent constructs and were adopted in the couples therapy discussed in Chapter 8, for example. Similarly, the individual case study unit suggested the quintessential importance of identifying 'co-dependent' social arrangements which may be contributing to any identified intrapsychic psychological dysfunction. Indeed, by maintaining an alliance with traditional as well as more radical psychotherapeutic positions, it is possible for the discursive clinical psychologist to facilitate a progressive phylogenetic evolution to a Clinical Psychology that becomes ever more invested in the philosophical tenets ('toolkit') of Discursive Psychology, which is understood to be the inclusive

theoretical yardstick for the optimal development of an optimally effective therapeutic psychology, of sorts.

**What is the way forward for the discursive clinical psychology project?**

In order to decide on the best way forward it seems necessary to firstly ascertain the *limitations* of this particular doctoral research endeavor before considering possible future studies which might rally support towards the conventionalization (Chapter 3) of a possible discursive clinical psychology model. It therefore seems necessary to establish a position on the following questions:

- Were the methods adopted for therapeutic efficacy evaluation valid and appropriate?
- Was the case study analysis sufficiently exhaustive to function as proof of clinical discursive psychology in practice?
- Was the therapist's personal identity position sufficiently articulated so to account for Discursive Psychology assumptions during therapeutic positioning activity?
- Which theoretical, practical and research areas of interest might be further developed for the discursive clinical psychology project in light of the case study analysis undertaken in this doctoral thesis?

We will critically discuss possible responses and implications surrounding these questions before finally concluding this thesis.

Carson, Butcher and Mineka make the following comments with regards to evaluating the success of psychological treatment:

> *"At best, it is an inexact process, dependent on imperfect measurement and outcome data. Attempts at estimating client's gains in therapy generally depend on one or more of the following sources of information: (1) a therapist's impression of changes that have occurred, (2) a client's reports of change, (3) reports from the client's family and friends, (4) comparison of pretreatment and posttreatment scores on personality test scores or on other test instruments designed to measure relevant facets of psychological functioning, and (5) measures of change in selected overt behaviors."* (p 677).

These methods of therapeutic evaluation include problems typically involved in any empirical study of the social world. For example, therapist's can bias research findings in favor of social honor with regards to his social identity as a healer. Moreover, therapeutic sessions are but one of many discursive contexts any individual enters in daily life and therefore provides a limited perspective on any person's life in relation to holistic change. Therapist's might inflate improvement rates by encouraging difficult clients to leave therapy early, which of course is difficult to interpret as therapeutic success or failure since in effect incomplete therapy cannot be evaluated on 'therapeutic

outcomes'. Clients who complete therapy therefore comprise a selected sample of individuals who do not necessarily represent the general population; any possible normative statistical analysis is therefore complexly confounded. A client, furthermore, may attempt to please the therapist by reporting improvement, or be invested in the 'getting well story-line' at a personal or social identity level, especially, for example, where time, money and emotional investment has been given to the therapeutic process. Similarly family and relatives may be biased in their evaluations although the authors report that family and relatives may be more 'realistic' in their evaluations than either the therapist or the client.

To overcome these biases, clinical ratings by an outside independent observer is sometimes effectively used as an attempt at 'objective' therapeutic evaluation measure, while psychological tests also foster the pursuits of 'objective measurement'. The latter may include 'before and after' testing formats although there are problematic theoretical twists to any attempt at objectifying and quantifying therapeutic change. For example, statistical information can be semantically reconstituted in multiple regression analysis to show differing therapeutic outcomes, or regression to the mean of high or low scores in any distribution may occur on repeated measurement - all potentially creating a false perception of therapeutic change. So too the tests per se used in any evaluation do not necessarily index any therapeutic change nor necessarily how the client may behave in differing everyday life contexts. Furthermore, discursive formulations such as 'recovery', 'moderate' or 'marked' improvement are given to variable interpretation. Cognitive-behavioral therapies are usually the focus of attention in clinical research where changes in pre-selected and specifically denoted behaviors that are systematically monitored tend to be the only form of 'absolute measurement', yet even rigorous empiricist method cannot account for certainty in measured therapeutic effects since placebo, other events in the client's life, or even spontaneous change might better account for any healthful life adjustment changes. Despite these problems, the authors report that empirical research by investigators such as Lambert & Bergin (1994) suggests that

> *"The chances of an average client benefiting significantly from psychological treatment are, overall, impressive".* (p 678)

The authors also report ten percent of clients who believe themselves to be worse off after therapy and account for therapist personal identity factors as primarily responsible since it is understood that therapists may experience difficulty working with certain kinds of people and/or cases.

The therapeutic evaluation methods used in this doctoral project are therefore an amalgamation of many of these possible methods for conducting clinical research, as these were informed by Discursive Psychology. That is, the client and therapist's perception of change (all three case

studies), the client's family and friends (all three case studies), pre- and post-treatment evaluation (collective and individual units), as well as measures of change in overt behavior (individual unit). All the criticisms leveled at any clinical research can therefore be directed at this study as well. However, it is contested that given Discursive Psychology philosophical foundations and process, these problems have been effectively accounted for in this research project; that is, sound methodological operation of the research process in terms of Discursive Psychology super-ordinate meta-theoretical principles which, by definition, necessarily attempt to redress any problems pertaining to methodology in empirical research into the social world and, therefore, automatically provides a philosophically consistent social research model which accounts scientifically for these issues. In line with Discursive Psychology meta-theoretical assumptions, this methodological refinement also therefore includes the original transcriptions of all the therapeutic encounters discussed in this thesis (Please refer to the compact disk included in this volume and instructions for use at the beginning of Part II). This has been deliberately undertaken so that objectivity may be supported - on reading the original data, the critical reader is in a position to come to their own conclusions. The reader is therefore invited to judge the therapeutic efficacy of this doctoral project for themselves by reviewing the full range of transcripts. In this manner, the reader might function as the final evaluator of the discursive clinical psychology therapeutic position, from the 'outside', so to speak, which is reportedly one of the more useful measures of therapeutic success or failure. Indeed, by including the exhaustive range of empirical data gathered and analysed during the clinical research investigation within the bounds of confidentiality and ethical requirements (see Chapter 6), it has been possible to further augment a thorough, valid evaluation of the discursive clinical psychology project - in this manner, multiple positions on the clinical material can be generated through which therapeutic evaluation might occur as this unfolds through critical appraisal over time.

From a Discursive Psychology position, therefore, this doctoral research project might be considered philosophically valid as a clinical research study and on the whole, all three case studies seemed to indicate healthful improvement of some sort through the therapeutic encounter. This is discussed in detail through Chapters 6-9, which should be understood to comprise one analytical unit for evaluation discussion of the discursive psychology project as rendered in this thesis. Further than this, however, it seems best to leave any final evaluation to the reader since any extended evaluation by the therapist will simply perpetuate the evaluation bias problems already discussed above.

It should, furthermore, be pointed out that although the research design attempted to demonstrate the therapeutic range of discursive clinical psychology by including collective, dyadic and individual therapeutic units, younger and older subjects, well adjusted and lesser adjusted subjects, and males and females in traditional and more alternative lifestyles, the therapeutic subjects were essentially

chosen at random (see Chapter 6 for full discussion) and comprise a minute sample group of possible patients and clinical problems. Therefore, further discursive clinical psychology case studies focusing on different clinical problems with different patient groupings and, perhaps, conducted by different discursively oriented therapists, would certainly provide necessary evidence supporting any possible conventionalization as a psychotherapeutic treatment modality; this doctoral project is simply introductory in nature - discursive clinical psychology still remains to be properly illustrated as an inclusive meta-theoretical position from which to coordinate therapeutic assessment, diagnosis, intervention, prevention and research during Clinical Psychology related social activity. Of course, all of these efforts should be scrutinized by arbiters of right action, such as other practicing clinical psychologists, theorists, teachers and academics, for example, as well as lay persons, students and patients and ex-patients of psychotherapy.

Another limitation of this doctoral research project involves the relative lack of personal identity commentary on the part of the therapist in relation to therapeutic activity. Indeed this is an important dimension of discursive clinical psychology to explore which needs to be both thorough and exhaustive, especially since Carson et al. report that this is an important variable affecting therapeutic outcome. This future investigation has unfortunately been precluded in this doctoral project given the natural limits of this philosophical overview and introduction of the discursive clinical psychology project, which in itself needed to be suitably thorough and exhaustive and indeed comprised the necessary first step towards a proper therapeutic psychology as defined within Discursive Psychology meta-theory.

Various points of interest arose during the case study analysis and discussion which might be further explored in subsequent discursive clinical psychology case studies or using Discursive Psychology principles and focus more generally, and include:

- neologisms: various research subjects used words that were not part of standard English nor colloquial phraseology. For example, Peter, the male partner in the dyadic unit case study, repeatedly used the term 'zikapika' (see transcripts, p 302, 309, 354, 538 and 578) which seemed to stand for a whole range of denoted and connoted meanings; that is, centering on meanings pertaining to 'nothingness', 'absence', on the one hand, and also to indicate a 'couldn't care less attitude' (e.g., I don't give a zikapika). This certainly might be analysed for latent (connoted) personal identity (e.g., Peter's persistent sense of having received nothing but criticism from others in his discursive worlds) or denoted discursive roots (e.g., zilch, zero, or indigenous South African tribal words) and therefore might inform both clinical therapeutic possibilities and other forms of research into psychological processes more generally. For example, it might be possible to deconstruct this neologism with Peter with regards to its unconscious discursive meaning for

him as his unconscious discursive assumptions impact on his marital relations in couples therapy. Alternatively, a discursive social psychology analysis might involve investigation into the creative discursive processes that originated the neologism, the process of its up take or rejection as a conventionalized speech-act within the legitimated discursive stock.

- closer investigation of how grammatical devices might be used to effect healthful therapeutic change. For example, that many therapeutic speech acts such as reflective listening, for example, on closer investigation during the case study analysis seemed to have involved a form of questioning and were therefore shown to be actively interrogative rather than passively reflective in nature. These findings suggest that traditional 'therapeutic discourse' might be more carefully deconstructed from a Discursive Psychology position, in light of facilitating perlocutionary shifts (healthful *action*) as well as illocutionary shifts (healthful *meanings*) in therapeutic discourse for effecting useful and enduring positive psychological change. Furthermore, this greater awareness of the centrality of grammatical processes in psychotherapy could also facilitate the active development of a whole range of discursive features never previously considered that may function as powerful therapeutic positioning devices. These unknown possibilities might be researched ad hoc, as well as by interfacing with fields such as applied and theoretical linguistics.

- the use of metaphor in psychotherapy and in discursive practices more generally is another area of investigation that this doctoral study has highlighted as an interesting focus of study. Indeed creative use of metaphor seemed to have been pivotal in shifting many of the therapeutic subjects in the case studies towards their self chosen therapeutic goals; for example, both play and family therapy in the collective unit case study relied heavily on metaphorical exercises indexing real discourses within the worlds of the young patient and his family, all of whom underwent psychological change fairly rapidly, as judged by the therapist in relation to typical child and family related cases (see Chapter 7). The metaphorical recursion of the conflictive communication sequences between the couples therapy partners during the moral dilemma role play towards the close of the therapeutic process seemed to assist the female partner in finally leaving their relationship given her perception of their mutual incompatibility as marriage partners and parents in a complex, reconstituted family (see Chapter 8). The individual psychiatric patient reported that the positive metaphorical reframing of his sad life circumstances as an agential moral career, assisted him in improving his sense of self worth and, in turn, his resolve to improving his life circumstances through his own concerted efforts (see Chapter 9). Indeed understanding the fine machinations of the discursive operation of metaphor in therapeutic discourse might provide productive insights into possible mechanisms supporting psychotherapeutic changes identified in psychoanalytic processes, for example. Perhaps a

Discursive Psychology understanding of the use of psychoanalytic metaphor, as conducted in psychoanalytic psychotherapeutic discourse, might explain the generative mechanisms responsible for psychotherapeutic improvement in both psychoanalytic approaches as well as more generally. This might arm the discursive clinical psychologist with more refined, chiseled and honed therapeutic tools for effecting optimal psychotherapeutic interventions.

Finally, *comparative* clinical research guided by Discursive Psychology principles for evaluating therapeutic efficacy might be usefully applied to purist traditional and radical approaches, various forms of therapeutic eclecticism, and/or renditions of different discursive clinical psychology readings as implemented by different discursive therapists. In this way, the underlying generative mechanisms supporting healthful psychological change during discursive therapeutic activity might become ever clearer, and through raising therapists' awareness of these discursive processes, and the progressive refinement of the discursive clinical psychology model, it may be possible to engineer better, more useful therapeutic principles, strategies and techniques for application during discursive therapy. Therapeutic subjects might therefore be assisted to improved, optimal life adjustment within the discursive fields of their personal worlds by choosing to undergo a discursive psychotherapeutic journey since each of us is necessarily positioned as both passive recipient and active agent within social discourse. By undertaking this journey, every human being can chose to liberate their sense of personal agency, and in this manner, create psychological wellbeing and meaning for themselves within the limitations of their discursive worlds.

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