Concealing and revealing power in the therapeutic relationship

Verbergen en onthullen van macht in de therapeutische relatie

(met een samenvatting in het Nederlands)

Proefschrift

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CHAPTER ONE
A CONCEPTUAL ORIENTATION TO POWER AND ITS CONCEALMENT

1.1. Introduction

Power has received little sustained and systematic attention in the therapeutic literature. While numerous influential authors and therapeutic figureheads have expressed views on the issue, it is seldom placed centre stage in a way that promotes the degree of attention afforded other therapeutic interpersonal processes, such as transference, ethics, dialogue, hierarchy or collaboration (Goldberg, 2000; Kuyken, 1999; Proctor, 2002). Power tends to be discussed only as a peripheral issue relative to other, more centralised topic of debate. But while it has stimulated only minimal theoretical coverage and empirical examination, most therapists are likely to have an opinion on the matter.

Given the privileges and responsibilities associated with therapeutic practice, it is important that this apparent failure to take power seriously is addressed. Indeed, such inattention makes it possible for therapists in training and in practice to overlook a number of questions that power is capable of bringing to the fore, and which are of crucial importance in understanding what sort of social and cultural practice therapeutic work is: How does power become available in therapy? To whom does it become available, and in what ways? How transparent are power operations and how amenable are they to empirical examination? Indeed, what forms do they take? What does power do in the therapeutic encounter? What psychological and interpersonal realities does it go on to produce, and through which techniques? What are its objectives, and how does it link up with social, cultural and political processes? And of course, how can power be opposed and transformed? This thesis attempts to develop a critical view on power to address these issues, building on some of the ideas of social theorist, historian and philosopher, Michel Foucault. A thread running throughout this work is power's concealment, which is offered to partially account for the relative lack of attention given to the issue in the therapeutic domain, and for the resulting impoverished "tool kit" of ideas on power from which therapists are currently able to draw. In response to this limitation, I aim to highlight some theoretical and methodological tools to enhance its empirical accessibility.

This first chapter lays the foundations for this series of studies by exploring, with special reference to therapeutic practices, (1) why it is important to study power, (2) how it is concealed, and (3) how we might undertake its examination. Following discussion on some of the reasons for studying power, it will be argued that power has been hidden in the therapeutic literature in four primary ways: through the conflation of power with its effects; in the relationship between power and knowledge; in the tendency to see power in decontextualised fashion; and through therapeutic re-descriptions of resistance. These discussions raise methodological issues, which lead on to the question of how to analyse power empirically. The use of a discourse analytic research methodology is argued for, together with the insights of rhetorical and discourse psychologists, as useful entry points into the examination of power dynamics in the therapeutic encounter.

1.2. Why study power?

1.2.1. Cautions against emphasizing power

Why should we study power in therapy? The issue is so contentious that this question already brackets out the opinions of certain influential therapeutic figures who maintain that centring on power is undesirable (e.g., Bateson, 1979; Hoffman, 1992; Keeney, in Madigan, 1994). On these accounts, the concept of power invites erroneous understandings of, and ethically dubious practices within, the therapeutic relationship. A key figure in this regard is Gregory Bateson (1972, 1979), who significantly influenced the growth of systemic family therapies from the mid-1950s onwards as well as prevailing attitudes to power in those approaches. He saw power as unilateral influence or control, which from within his cybernetics outlook constituted an epistemological error: a "myth" (1979, p. 243). But it was nevertheless considered a dangerous myth that could have real effects: persons who believed in the possibility of power might try to exert unilateral influence over others. Applying Bateson's thoughts to the therapeutic domain, Hoffman (1988) has argued: "The therapist is part of a mutual system of influence, and the power idea obscures its recursive nature" (p. 66). Similarly, and also drawing from the work of Bateson, Weakland (1993) suggests that the notion of power obscures from view the way in which "each party necessarily influences the other… The client needs the therapist's expertise and help, but the therapist needs his (sic) fee and the client is the customer – hierarchy cuts both ways" (p. 144). Fruggeri (1992) also considered power, again seen as unilateral influence, to be a misleading and erroneous concept: "The therapist does not have the power to change nor unilaterally to determine the direction of change" (p. 47).

While some systemic authors pressed for more nuanced attention to power (e.g., Flaskas & Humphreys, 1993; Golann, 1988), it became a bothersome issue to many operating within that tradition. It seemed to introduce a troubling individualistic and linear way of thinking (i.e., power as unidirectional influence) that challenged the interactive and circular epistemology that systemic therapy holds at its core. The issue became so contentious that in some instances certain systemic therapists expressed a wish not to discuss it at all (c.f., Hoffman, 2000; Keeney, in Madigan, 1994). The main concern is that the concept of power emphasises a distasteful feature of relationships, and predisposes to and enhances any inequality that may be evident within them. Cecchin (1992) aptly underlines the fear of many systemic therapists: "If you believe too passionately in the controlling aspects of therapy, you can become a social engineer" (p. 93). On the other hand, the argument goes, if one emphasises the more desirable collaborative aspects of an interaction, these features are more likely to be brought forth and reproduced (Hoffman, 1992; Keeney, in Madigan, 1994). Thus, many systemic therapists do not consider power a useful way of interpreting a therapeutic interaction, and effectively sidelined it as an issue worthy of detailed theoretical exploration. (Nevertheless, some ideas on power have emerged from the systemic literature, to be discussed below in section 1.3.3.)

For slightly different reasons, though having evolved an approach partly out of the systemic perspective, collaborative language systems therapists Anderson

and Goolishian (e.g., Anderson, 1997; Anderson & Goolishian, 1988; 1990) also suggested that power need not be explicitly theorised. Their focus was not on the client or family as systems; rather, they employed more recently developed constructionist understandings to locate clients within systems of meaning. Hence, they considered that the problem of power is not that it is an epistemological error, or that it precludes a view of circular interactions (as claimed by systemic authors), but that it is a real product of particular ways of using language. Specifically, they expressed concerns about the therapist's use of observational, expert language - including that of systemic theories - to depict the client (Anderson & Goolishian, 1990). Such language, or knowledge, puts the therapist in a "one-up", hierarchical position, and thereby restricts the client's options for the discovery of new self-narratives. According to these authors the danger is that in expert oriented practices, the client would simply reproduce and re-enact the narratives proposed by the therapist, and genuinely new and self-authored ideas could not emerge (see also Hedges, 2005). Power *need not* be theorised, on this view, because the exercise of power by a therapist is simply bad and ethically problematic therapy. It needs to be noted as a danger, but then avoided. Hence, Anderson and Goolishian indicate that power can be eliminated via egalitarian practices, and therapist performances of transparency and respect (e.g., Anderson, 2001; Anderson & Goolishian, 1990; see also Hoffman, 1992). (This approach will be addressed in more detail in chapter 6.)

While these related systemic and collaborative-constructionist approaches may have only minority representation across the range of therapeutic professions as a whole, they are noteworthy for their significant influence on the development of theory and practice in systemic-family and constructionist therapies.

1.2.2. Power and a view of ethics

On the other hand, many more therapists and authors of a variety of theoretical orientations (some *within* systemic and constructionist therapy) would consider power to be a less dangerous topic than depicted above. Arguably the prevailing position is an unstated one: power is implicit in the attention given to ethical issues pertaining to a therapist's influence of the client. The argument here is that if power is not at least noted, abuses or misuses of power become more likely (e.g., Bird, 1994; Boscolo & Bertrando, 1996; Carpenter, 1994; Goldberg, 2001; Kuyken, 1999; Levold, 1988). Indeed, the generation of ethics codes and guidelines in the therapeutic professions constitute formalised protections for clients against abuses of power. The power afforded the therapist is seen to be present and potentially dangerous, and so structured and institutionalised protections for clients become necessary.

However, many argue that professional codes of ethics do not adequately protect clients from the power techniques that therapists are legally and professionally *entitled* to exercise, but which are nevertheless ethically questionable (e.g., Brown, 1997; Kuyken, 1999; Proctor, 2002; White, in Hoyt & Combs, 1996). Thus, while some systemic and constructionist authors emphasise collaboration in order to avoid power, as discussed above, there is in certain other practices the risk of power not being taken seriously enough. For example, Proctor

(2002) notes that inattention to the issue in cognitive behaviour therapy allows its practitioners to use what she considers to be paternalistic and coercive tactics, and to justify these by appealing to the ethical principle of beneficence: if a client gets better, the practice is deemed ethical. Similar rationales are evident in the practices of some strategic therapists, who rely on the assumption of an authoritative role in therapy, and use tactics of directive instruction and even of fear and deception to promote therapeutic change (e.g., Haley, 1976; but see Lankton, 2000, for a more collaborative emphasis in this approach). In these instances it seems that power tactics are justified by a rather blunted account of ethics, which privileges predetermined client change above all else and risks conflating ethics with effectiveness.

For Kuyken (1999) and Proctor (2002) ethical practice should go further than narrow determinations of success and failure that seem overly emphasised in some practices. Furthermore, calls for "empirically validated" therapies and for the related prioritisation of pre-therapy and post-therapy assessments to measure effectiveness, risk legitimising a simplistic instrumental take on the ethics of intervention. Thus, both Kuyken and Proctor recommend the concept of power to lend nuance to our sense of therapeutic ethics, and thereby to promote therapy's status as an ethical practice. Kuyken does this by proposing means for identifying and resolving "grey areas" that seem to hang delicately between power and its abuse, while Proctor uses the notion of power to facilitate, among other things, attention to the client's experiences of therapy. Indeed, attention to power dynamics can help highlight not only the problems associated with a push for therapeutic effectiveness, but also some of the more subtle, unintended but nevertheless ethically dubious effects of various clinical practices. These include: the mystification of therapy and the therapist; the objectification of clients; the use of pathologising language in discussions about clients with other professionals; and the tendency to impose meaning or interpretation on client experience (e.g., Bird, 1994; Carpenter, 1994; Gannon, 1982).

Powerful critiques of the limitations of structured ethics codes have emerged most notably from narrative and feminist sources. In an interview on the issue, White, one of the founders of narrative therapy, distinguishes between these ethics codes and "personal ethics" (in Hoyt & Combs, 1996, p. 50), which are more sensitive to issues of power than the "rules" of a psychological or therapeutic society. He refers to the following as examples of a personal ethics: "working collaboratively in the world" rather than "acting… on the world" (p. 52); taking responsibility for noting and addressing the consequences of our actions on the client; situating our actions and beliefs in terms of our "ethnicity, class, gender, race, sexual preference, purposes, commitments" (p. 52); developing "an attitude of reverence" (p. 52) for the client; and a "commitment to challenge the practices and structures of domination of our culture" (p. 53). Like the authors noted above, White believes that careful attention to power issues can foster ethical sensibilities that transcend those of any formal ethics code and promote the identification of more subtle ways in which we might unwittingly silence, marginalize or undermine the client and his or her potentials.

Feminist clinical psychologist Brown (1997) has also noted limitations of formal ethics codes, and offers through the Feminist Therapy Institute (FTI) an alternative conceptualisation of ethics. She criticises most formal ethics guidelines

for simply accepting the therapist-client power imbalance as an unproblematic given, and argues that there is little evidence that psychologists consider "the equalisation of power as a goal for ethical behaviour" (p. 61). The aim was to have the FTI code developed in a consultative rather than hierarchical manner, and clients' opinions were included in its construction. Like the personal ethics of White, this code emphasises the need for therapists to be concerned with issues outside of the therapy room, and to be – amongst other things - actively involved in challenging social injustices at a socio-cultural and political level.

Two main points emerge from this discussion of White's narrative account and Brown's feminist position. First, both refer to the limits of traditional ethics codes and declare an interest in the democratisation of the therapeutic relationship. In this respect they are joined by many others (e.g., Anderson, 1997, 2001; Bird, 1994; Carpenter, 1994; Goldberg, 2001; Hoffman, 1988, 1992). However, it should be noted that White, in particular, acknowledges that such democratisation can never be fully realised. Thus, despite critiques of his work to the contrary (e.g., Fish, 1999), he accepts that there is a power differential between therapist and client, but works at the same time (1) to undermine this difference and minimise its effects by inviting the client to join him in distrusting the influence of his own location (in the world of gender, race, culture, sexual preference, professional status, etc.) on his statements, and thereby render them vulnerable to critique; and (2) to use his position of power to join people in challenging the socially and culturally dominant discourses that have impacted negatively on their lives, and against which they have chosen to struggle (in Hoyt & Combs, 1996).

But White and Brown differ from many others who share their egalitarian impulse in at least one fundamental respect. And so the second point is that both advocate an expansion of what is typically meant by therapeutic ethics: ethical practice must take into account what goes on *outside* of the consulting room. Let us turn now to that issue.

1.2.3. Power in therapy as reproducing social inequality

Brown and White point to a second set of reasons for studying power, which goes beyond the narrow ethical question of the therapist's influence over the client. Specifically, they are concerned with the relationship between therapeutic happenings and broader socio-political processes. The question here becomes: Does the inequality of the local therapeutic power relation reflect or reproduce inequalities in broader institutional, discursive and political processes? Concern has been expressed with respect to therapy's potential to reproduce gender (e.g., Davis, 1986; Gannon, 1982; Hare-Mustin, 1994), racial (e.g., Totton, 2000) and cultural (e.g., Holdstock, 2000; Pilgrim, 1997) power arrangements that predominate in the broader socio-political sphere. These concerns are important, because they suggest that therapy should not simply be accepted as a haven or refuge from dominant discourses and practices in the surrounding culture, but as an integral and active part of these institutionalised arrangements.

There are two primary issues here, one particular and one general. First, there is the concern that the inclinations of a particular therapist or theoretical orientation might lead to the reproduction of societal inequalities. This concern

can be met with a variety of interventions, including countertransference analysis in psychoanalytic therapy (Frosh, 1987), the utilisation of more socially and culturally sensitive theoretical accounts of the person (e.g., Holdstock, 2000; Hermans, 2001), and critiques of the politics of specific approaches (e.g., Proctor, 2002). But there is a second and more general possibility: that *therapy itself* might somehow already be designed, or may be positioned within the overall sociocultural organisation of institutions and practices, in such a way that it leans towards reproducing whatever societal power relations happen to be in place at the time (c.f., Parker, 1998; Rose, 1998). If this is the case, then, as Hare-Mustin (1994) warns, therapists risk functioning as unwitting agents of "social control more than social change" (p. 20); as conservative political agents (c.f., Hurvitz, 1973; Goldner, 1993).

While this thesis will investigate particular approaches, it does so in the overall interests of exploring this second and more general possibility. But the question of therapy's societal functioning is a complex one, and should not be considered in a linear or hierarchical fashion. Therapy's operations may be influenced by the societal context, but they are not determined by it. And in this sense a focus on particular approaches, rather than only on the therapeutic industry as a whole, becomes an important avenue of exploration. Indeed, many authors and therapists have attempted to construct therapeutic practices that facilitate challenges against prevailing cultural norms, the societal management and subjectification of individuals, and other systems of government and domination. In other words, there are many practitioners who have noted the risk of *particular* therapists and approaches reproducing societal power arrangements, but challenge the more general idea that therapy itself needs to be implicated in such reproduction. For example, as has been discussed, feminist therapists (e.g., Brown, 1997) and narrative therapists (e.g., Monk & Gehart, 2003; White & Epston, 1990) aim to join clients in challenging those socially dominant discourses and practices that capture persons and orient their actions and subjectivities to the unwitting recycling of predetermined political strategies. In similar vein, it has been argued that psychoanalysis has "emancipatory" potentials, enabling persons to recognise and overcome the ways in which institutionalised relations of power, and the forms of rationality they embody, intimately infiltrate and shape processes of self-construction, distort communication, and impede the accurate recognition of self and other (e.g., Habermas, 1972/1987). The potentials of feminist, psychoanalytic and narrative approaches to function critically – to question rather than conform to societal power relations - will be discussed in more depth in chapters 5, 7 and 8, respectively.

Posing the question of the relationship between local therapeutic practices and macro, societal arrangements leads to an expansion of the issues we usually associate with power. We must go beyond exploring the ethics and/or therapeutic benefits of one person influencing or controlling another (which is, I suggest, how power tends to be understood in the therapeutic domain), and examine also how this influence links in with broader power related processes in society in general. Each of these issues - the micro (within-therapy) and the macro (extra-therapeutic political strategies) – is important in its own right; but the relationship between them makes the study of power in therapy imperative.

1.2.4. The concealment of power

Despite these divergent and multiple concerns about power, it has been inadequately theorised and debated as a clinical or therapeutic issue (Goldberg, 2001; Kuyken, 1999; Flaskas & Humphreys, 1993; Proctor, 2002). White and Epston (1990) have pointed to an "impasse" in conceptualising power in the therapeutic literature (at least up to the time of their 1990 text), caused by the simplistic terms of the debate: power as oppression (e.g., Anderson & Goolishian, 1990); and ongoing debates over whether or not power exists (e.g., Bateson, 1979; Hoffman, 1988). White and Epston (1990) argued that power could not be understood under such conditions. While the issue has received more discerning attention in more recent years, wherein power has been opened up conceptually to transcend such simplistic dualisms (e.g., Flaskas & Humphreys, 1993; Hare-Mustin, 1993; Proctor, 2002), it seems that the therapeutic professions in general have failed to highlight its significance as an issue requiring discussion or theorisation.

How we go about discussing power is frequently a source of confusion and uncertainty among therapists. Indeed, Goldberg (2001) maintains that power is the single most neglected issue in the training of therapists. Unlike White and Epston, he provocatively points to dishonesty in the profession as the cause of this neglect, and questions the ethics and morality of the allegedly widespread tendency to deny power related processes - of expertise, influence, interpretation, persuasion - by labelling therapeutic work as "democratic" or "collaborative" (see also Bird [1994] and Proctor [2002]). This unforgiving stance should perhaps be tempered, however, through consideration of another factor that has facilitated the field's reluctance, or even inability, to deal with power in more comprehensive manner: power is often concealed (Foucault, 1990).

And so we arrive at the final, compelling reason why power should be studied. According to Foucault (1988) "relations of power are perhaps among the best hidden things in the social body" (p. 118). Many therapists have noted this feature of power, although from a variety of perspectives, and propose that language can be used to hide power. Hoffman (1992) suggests that "our practices should reflect an awareness of hidden power relations" (p. 22), although she does not articulate how this might be achieved, or precisely what is being hidden. Her aim, nevertheless, is to work collaboratively in an effort to reduce the effects of power in therapy. Similarly, as noted above, Anderson and Goolishian's (1990) emphasis on collaboration and equality is intended to counter the operations of power inherent in the exercise of expertise. They argue that by using knowledge to construct expert descriptions of an individual or a family, therapists exercise "power and control" under the guise of objective truth (p. 160).

However, in White's ongoing struggle with his own authoritative position as a therapist, he warns that claims of equality, collaboration and the de-privileging of expertise and specialist knowledge are dangerous to the extent that they allow therapists to avoid the necessary monitoring of what actually occurs in practice (Hoyt & Combs, 1996). That is, such claims might promote further concealment of power operations. Coming from a different theoretical perspective, structural family therapist Salvador Minuchin shares White's concerns in this regard. He argues that power is hidden precisely when attempts are made to remove it

through collaborative practices: "Control does not disappear from family therapy when it is renamed 'cocreation'. All that happens is that the influence of the therapist on the family is made invisible. Safely underground, it may remain unexamined" (Minuchin, 1992, p. 7).While White chooses to deal with this difficulty by questioning himself and inviting the client to do the same, Minuchin's solution is very different. He proposes the open and explicit adoption of a hierarchical position of expertise.

Minuchin is united with others (e.g., Golann, 1988; Haley, 1976; Nichols, 1993) in the view that power is rendered visible, and hence is more ethically justifiable, to the extent that it is nakedly exercised, provided care is taken to avoid its abuse. These authors contradict the suggestion that expertise hides power behind knowledge, by arguing that knowledge and expertise can be laid open to view, and used in an explicit and transparent attempt to influence the client benevolently (Haley, 1963), in a predetermined therapeutic direction. This position is consistent with other directive practices that prioritise brevity and symptom reduction, such as psycho-educational, behavioural and cognitive-behavioural therapies (Boscolo & Bertrando, 1996; McCrady, 2000; Proctor, 2002). However, it is a position that Anderson, Goolishian and Hoffman (and numerous others, for example in the constructionist, systemic, narrative, feminist and person-centred traditions) find not only ethically intolerable, but also therapeutically limiting.

While there is some recognition in the therapeutic literature of power's capacity to be hidden, I will argue below, and indeed throughout this work, that this concealment is resolved neither through a de-privileging of knowledge (e.g., Anderson & Goolishian, 1990) nor via transparent acknowledgements of expertise (e.g., Haley, 1976; Minuchin, 1992). Such local strategies for dealing with power address only a very small portion of power's functioning – its local effects - and obscure from view the complex pathways through which it traverses before it enters into, and after it exits from, the therapeutic relationship. The obvious problem that the concealment issue raises here is that power can only be discussed to the extent that it is visible. But as a relatively invisible, or hidden problem, the identification of power's mechanisms, and of the therapist's participation in these, becomes imperative.

1.3. Concealing and revealing power

Having examined some of the reasons why power should be studied, attention now turns to the ways in which it is made invisible. I will draw from the work of Foucault in the ensuing discussion. It should be noted that numerous therapists have employed Foucault's work to in attempts to provide a more sophisticated theory of power, as it pertains to therapeutic practice, than has until recently been available in the therapeutic literature (e.g., Flaskas & Humphreys, 1993; Foote & Frank, 1999; Hare-Mustin, 1993; Keenan, 2001; White and Epston, 1990). I will draw on these works but aim in the end to produce an account of power that is not intended to be used in the service of therapy – as these authors have done – but more precisely to provide conceptual and methodological tools for the critique of the therapeutic industry as a whole. This will be attempted via analyses of local operations of power within therapy, but also through

examinations of therapy's location in the broader socio-cultural and institutional context.

It should also be noted at this point that Foucault's work was at times inconsistent and contradictory (Fish, 1999; Hindess, 1996), especially regarding the relationship between power on the one hand, and knowledge, domination, resistance and the person on the other. Some of these inconsistencies will be referred to below, but they will ultimately be subverted in my attempt to construct a coherent theoretical approach - drawing more on Foucault's later rather than earlier work - specifically designed to afford an examination of power relations in therapeutic practice.

It is argued here that therapeutic operations of power are concealed in at least four ways: through the conflation of power with its effects; the concealment of power in knowledge; the divorcing of power from its context; and therapeutic reconstructions of resistance. I will discuss each in turn.

1.3.1 Distinguishing power from its effects

In order to understand how power conceals itself, it is necessary to consider what is meant by the term. Power, according to Foucault, is not a substance. It has no form, no organisation, and it is not "stratified" (Deleuze, 1988). It has no inherent function or strategy, other than its own perpetuation. Power, in other words, is invisible. On the other hand, those power-related processes that are visible, sayable or tangible are examples, according to Foucault, not of power per se, but of *effects* of power. This distinction of power from its effects is enabled by Foucault's (e.g., 1980, 1990) "positive" account of power. It is considered a productive force, and it is typically only its products that are open to view.

In this sense, Foucault's view differs fundamentally from more traditional views of power as a repressive or oppressive force. This difference underlies much of the tension between his work and that of one of his key contemporaries, Jurgen Habermas (e.g., 1972/1987). Their disagreements on power have been the subject of much debate, and they present views that have been so influential, and yet which contrast so fundamentally, that Flyvbjerg (2000) has characterised Foucault and Habermas as each other's "shadow". While Habermas' views will be discussed at length in chapter 7, it is worth noting here that he aligned with Freud's psychoanalytic emphasis on the repressive features of power, and saw power as a force that distorts and deforms what he considered to be a fundamental "human interest" in rational and undistorted communication. This is the sort of "negative" view of power against which Foucault's later work was oriented: a power that prevents, refuses, and distorts, and which hides truth in the process. But Foucault instead draws attention to what power *does;* the *products* of the exercise of power, even in those situations we would ordinarily characterise as oppressive. Consider, for example, a therapist who actively silences or undermines a client's opinions through interruption or expertly constructed and authoritatively imposed interpretations of the latter's experience. To assert that the client is being dominated – for instance, being prevented from expressing his or her "real" views – only partially accounts for what power is doing in that interaction, or for what such domination achieves. Such a formulation points only to what power may be preventing from occurring (a

negative account); but not to what the effects of this power might be (a positive account).

A positive account calls for a distinction between, among other things, power and such visible interpersonal processes as influence, control, hierarchical arrangements and persuasion – the things usually discussed when the concept of power is invoked in the therapeutic literature. This is not to say that power is not involved in the production or maintenance of these forms of relationship; rather, power is not identical with these processes. Influence, domination, persuasion, and so on, may be *evidence, outcomes,* or *products* of power, and they may function as vehicles for power, but they do not in themselves constitute power. Instead, power refers both to the products of these relationship features, and to the processes by which these features come into being.

Nevertheless, therapists and authors frequently attend to power precisely *as* influence, domination, persuasion or hierarchy (to be discussed below). Such theoretical conflation predisposes to confusion and inconsistencies in discussions on the issue, and promotes power's concealment. It may lead to the posing of "power-related" questions that focus on power's effects rather than on power per se. Thus, we find the following types of questions in the literature: How does influence work in therapy (e.g., Frank & Frank, 1991)? Does therapy involve hierarchical interactions (e.g., Golann, 1988; Nichols, 1993; Simon, 1993)? To what extent is the influence of the therapist on the client ethically acceptable (e.g., Anderson & Goolishian, 1990), and where are limits of influence to be appropriately drawn (e.g., Aveline, 1996; Kuyken, 1999)? Obviously these questions are important, but they succeed only in referring to, and in some cases problematizing, power's *effects*. In so doing, the processes by which these effects come into being may be difficult to appreciate. There is the risk that even in explicit discussions of power, its means of production may remain concealed. On the other hand, Foucault's analysis invites us to consider different kinds of questions - requiring a different level of analysis than that implicit in the above questions - which explicitly attend to power's means of producing effects: What sociocultural arrangements make local therapeutic power operations possible and productive? What "powers", or mobilises and animates influence or domination in therapy? What are the products of such interactions? What makes it possible for persuasion or hierarchical arrangements to become actualised and put into practise? From where does the therapist gain an entitlement to influence the client? What persuades the client to be persuaded in a therapy setting? Such questions point us to the conditions under which exercises of power become possible.

Consider, for example, a paper notable for its title in this regard: "Power and clinical psychology: a model for resolving power-related ethical dilemmas", by Kuyken (1999). To be clear, Kuyken addresses clinical psychology specifically, and therapy only insofar as it pertains to clinical psychology practices. His main question is: How do we recognise and address "power-related ethical dilemmas" (p. 21)? As already noted above, Kuyken distinguishes between power and its abuse or misuse, accepting power itself as inevitable and inherent in therapy, and abuse or misuse as embracing a range of abusive actions, ranging from the obvious and overt to the less obvious and covert. What is assumed in his paper, and is ethically approved, is the therapist's influence over the client. This much is

baldly stated – rather than debated - as a given in the first pages of the article (he also points to some ways in which the client can exert influence on the therapist). The "power-issue" considered is not power itself, but its abuse: *excessive or abusive* influence. And yet in terms of the view of power being constructed here, both influence and abusive influence are deemed effects of power. As Kuyken conflates power with its effects, he does not consider the questions of how such influence is legitimised in the first place, what its products might be, what social, cultural or political factors make it possible, or what might make differential degrees of influence (i.e., the therapist more than the client) seem necessary or justifiable in a therapeutic setting. The result, I suggest - despite the title and avowed intention of the article – is a failure to address power at all.

Indeed, Kuyken is by no means alone in this regard. For instance, family therapy debates on power, spanning many systemic, constructionist and narrative practitioners, frequently involve the conflation of power with its effects, such as hierarchy, control and domination (e.g., Anderson & Goolishian, 1990; Golann, 1988; Haley, 1976; Hoffman, 1988; Minuchin, 1974, 1992). Of course, this issue has more than semantic significance. The point is not simply that I believe the term is being used incorrectly (although its conflation with other concepts limits our view of what we can say about subtle but important differences between power, control, direction, etc), but that the processes that enable influence are seldom raised. That is, the power relations and procedures that support, undermine, transform, make possible or less likely the therapist's influence on the client (or, for that matter, the client's influence on the therapist), cannot be systematically and cogently attended to if these levels of analysis are not distinguished. And so, if the conditions of, and precursors to, local (i.e., therapist-client) influence are not exposed, power remains concealed, and can be at best only perfunctorily addressed. But more than this, with power concealed, it becomes difficult to recognise some of its effects *as* power effects. Frequently, it is only power's more distasteful and most obvious effects that are identified. The question this poses for us is: What therapeutic techniques or procedures may be power-effects, but going by some other name? In order to consider this question, we need to turn to what Foucault considers to be the primary way in which power is concealed: knowledge.

1.3.2. Power and knowledge

Foucault (1980) makes the point that erudite, formalised knowledge is (in part) one of power's effects, and yet this aspect of knowledge is frequently concealed. Power, being formless, and lacking in organisation, purpose and structure, relies for its exercise on some form of order and concretisation. Without this it remains "virtual" (Deleuze, 1988). It must become bound with some kind of form in order to become actualised, to derive purpose and direction. But in order to operate most efficiently it must adopt a form that implicitly rationalises or justifies its exercise. Knowledge provides power with form and, significantly, a rationalisation, which amounts to a form of concealment. But the power/knowledge relationship (Foucault, 1980) must be considered a dynamic, two-way process. The two are fundamentally interconnected:

> Knowledge and power are integrated with one another, and there is no point in dreaming of a time when knowledge will cease to depend on power; this is just a way of reviving humanism in a utopian guise. It is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power (Foucault, 1980, p. 52).

Knowledge and power should be considered mutually productive, working together to produce effects – e.g., pleasures, discourses, and relationships of power involving persuasion and hierarchical arrangements – while simultaneously concealing the power processes by which these effects are formed. On the one hand, knowledge gives power direction, form, a rationale and a set of objectives. On the other hand, power provides knowledge with force, or impetus, enabling it to have productive effects. In this way, power "forms knowledge" (1980, p. 119). For example, knowledge claims of therapists tend to be more productive of social realities than those of their clients. In other words, power's provision of force allows for the production into reality of that which knowledge delineates. And thus, we can say that their inseparability from power turns knowledges into discourses: "practices that systematically form the objects of which they speak" (Foucault, 1972, p. 49). When bound up with power, knowledge becomes more than a collection of words: it becomes a reality shaping practice.

The power/knowledge link is crucial to understanding power operations in therapy. It suggests that therapeutic objects (that which therapy "knows" or tries to know about) – such as depression, self-esteem, transference, etc – might be products of the therapeutic power/knowledge nexus, and not necessarily ontologically extant entities that discourse helps us to discover or uncover. We are invited to consider that these objects may be (in part) effects of power, that is, products of a binding of knowledge and power, rather than processes or entities that knowledge represents, and allows us ostensibly to measure with interviews, psychological tests and questionnaires, or to remedy with therapeutic interventions. Hook (2001) makes this point in a detailed analysis of a psychodynamic therapy session, using a grounded theory methodology. He argues that therapist-client talk can work to produce the very problems that therapy is designed to address. (This idea is discussed further in chapter 5.)

If knowledge and power work together to produce knowledge objects, then Anderson and Goolishian's collaborative language systems approach provides a challenge to the charge that therapeutic relationships always involve power relations (e.g., Kuyken, 1999). These authors have tried to disentangle power from knowledge in therapeutic work (e.g., Anderson, 1997, 2001; Anderson & Goolishian, 1990). Emerging from their concerns about the imposing effects of expert knowledge is the proposal of a "not-knowing" therapeutic stance. To be clear, this is not a claim that the therapist does not have knowledge; rather, it is a call for formal knowledge to be suspended in the encounter. These therapists suggest that in not-knowing they eject power from the relationship (or perhaps prevent it from entering in the first place – this is unclear in their account), and provide the client with freedom to explore and develop new narratives in his or her own preferred manner. The therapist engages in "dialogue" with the client, here considered a power-free and egalitarian conversational process, from which

the interfering dictates or inclinations of professional knowledge are apparently ousted.

Implicit in the influence of knowledge is its embodiment in the form of experts: those persons socially and professionally constructed as "truth tellers" (Rose, 1994). Anderson and Goolishian refuse not only the exercise of knowledge (and power), but also the adoption of the traditional expert position. They recognise the intimate relationship between knowledge and power on the one hand, and designated expertise on the other. Expertise is facilitated in therapy discourse's formalised distinction of "subject positions" (Burr, 1995; Willig, 1999) for participants. These are the positions into which people are interpellated, or called, by discourse. Therapeutic knowledges thus call forth the principal positions of therapist (expert knower) and client (non-expert known) (see especially chapters 2, 3, 8 and 9 for elaborations of this idea). However, Anderson and Goolishian's not-knowing position aims to undermine the therapist's expert positioning, and to correspondingly position the client as expert knower of his or her life experience: the traditional complementary positions of knowing-expert and known-client are thereby destabilized.

Many others join these authors in questioning what it is to have therapeutic expertise, and propose a shift towards understanding expertise in terms of process issues (e.g., hosting a therapeutic conversation) rather than in terms of matters of content (e.g., diagnosing or interpreting the client's experience) (e.g., Amundson & Stewart, 1993; Bird, 1994; Hoffman, 1988; Madigan, 1993; Tomm, 1987). Discourses that construct the client as an object of knowledge are specifically called into question, and rejected as a means for conceptualising what goes on between therapist and client. The questions these authors, together with Anderson and Goolishian, therefore pose for us are as follows: If, as has been argued, power and knowledge are mutually supporting, then what is the effect on the power relation if we remove expert knowledge from therapeutic work? Are there any power-related consequences of such a move? These questions will be addressed in more detail in chapter 6.

1.3.3. Power's location: the problem of context

One of the possible consequences of conflating power with its effects is the creation of a specifically local, decontextualised formulation of power. It becomes possible to believe that attempts at a local democratised therapeutic practice (through which power's most obvious interpersonal effects, such as persuasion, domination and hierarchies are challenged and undermined) can sufficiently address (e.g., Bird, 1994; Carpenter, 1994), if not solve (e.g., Anderson & Goolishian, 1990), the problem of power. This localised view of power is implicit also in attempts to remove power from the therapeutic relationship via the marginalization of professional or content knowledge: it is left to the intentions of local participants to create or avoid the creation of a power relationship. Further, in some cases, limiting the problematization of power to those actions considered "abuses" of power (e.g., Aveline, 1996; Kuyken, 1999) may limit the extent to which we can analyse precisely how power becomes available in a therapeutic encounter in the first place, and restrict our view of what social or cultural

procedures or knowledges are used to justify or rationalise its deployment in that setting.

Power *is* a contextual problem. It refers to a set of processes that are by no means exhausted by the sum total of participants' actions in any interactive situation. This means that we cannot understand power merely by examining the intentions of participants (as suggested by Anderson, 2001). The analysis of power should not be aimed "at the level of conscious intention or decision" (Foucault, 1980, p. 97). This point is recognised by narrative therapists White and Epston (1990), who contend that we cannot understand power relations by examining "personal motives" (p. 29). Similarly, in her Foucaultian analysis of patriarchal discourses in therapy, Hare-Mustin (1994) argues that power relations "cannot be explained by the intentions, good or bad, of individual men and women" (p. 22).

Moving outside of intentions then, we might try to understand power in terms of local actions and interactions. Indeed, many (but not all – e.g., Haley, 1976; Minuchin, 1974, 1992) systemically oriented therapists argue that power must be seen as an interactive process. It has no meaning outside of an interaction, and cannot be "taken" or "used" by an individual, regardless of his or her intentions, without the willing or unwilling participation of another (e.g. Flaskas & Humphreys, 1993; Fruggeri, 1992; Hoffman, 1988). Here, the apparent "power" of the therapist – for instance in the form of a complementary relationship of dominance-submission – is something therapist and client achieve together.

This view not only creates ethical problems (Jones, 1993), for instance by enabling the construction of a client abused by others - or indeed by her therapist - as a co-facilitator of her own abuse, but it also fails to adequately highlight power's contextual nature. By moving from intentions to local system dynamics, it merely shifts the focus from inside one person to the local therapeutic context of two persons interacting. But it remains an intra-therapeutic and local, decontextualised account of power. As will be argued in the chapter 6 discussion on collaborative therapy, exclusive focus on the local interaction entails an implicit assumption that there is a therapeutic boundary that is impermeable to broader social, cultural, institutional or discursive processes. If we consider power to refer to the interactions of therapist and client, what are we to make of these macro processes? I argue, along with many others (e.g., Hare-Mustin, 1993; Swann, 1999; White & Epston, 1990) that the workings of power within therapy are significantly shaped by broader social, cultural, discursive and institutional processes. This means that when we study power relations within therapy, we have to also consider their location with the entire "diagram" of power (Deleuze, 1988). Power can be neither created nor dismantled within therapeutic interactions, since therapy is only one small aspect of the societal "diagram of power": it is merely one of power's multiple terminal points. This means that the various attempts to address power at a purely local level that have already been mentioned - attempts at democratization; avoiding its abuse; ejecting power from the encounter; or understanding its local systemic features - can only be met with limited success, since the problem of power exists prior to, and is merely deployed into, any local therapeutic relationship. Power should be seen, in other

words, as a process whose specific applications are merely its "ultimate destinations… where it becomes capillary" (Foucault, 1980, p. 96).

If power is to be understood in terms of its overall context, how should we define it? It is notable that references to power in the therapeutic literature often proceed without any attempt at definition, which once again points to the conflation of the term with others like control or hierarchy, as discussed above. Nevertheless, Kuyken (1999), drawing on a host of proposed definitions, defines power as "the degree of control or influence that a person or group could or does have over other persons or groups" (p. 22). This definition is important for the likely consonance it has with prevailing ideas on power in the therapeutic professions. Kuyken suggests that power is located within the domain of the local interaction, and is something to be "had" and then used by one person or group to "control or influence" another. In addition to its blurring of the power-effects distinction, this definition renders power a static concept, the conceptual role of which is limited to posing as the ethically acceptable counterpoint against which to measure its abuse or misuse. The processes by which the abilities to "control or influence" become possible, more likely or less likely, or are justified, are not raised as salient issues. Power's contextual status is hidden from view.

Let us consider an alternative definition, proposed by Foucault in his later writing, which points towards matters of context. He describes power as "a total structure of actions brought to bear upon possible actions: it incites, it induces, it seduces, it makes easier or more difficult" (Foucault, 1982, p. 220). As well as highlighting power's positive dimensions, this definition also makes space for seeing power in context. Foucault refers specifically to a "*total structure* of actions" that impact on the actions of a person. Power is always *ensemble or organisation* of actions, in which individual actors and their actions merely play a capillary and expressive role. As suggested earlier, this allows us to study a host of therapeutic variables as themselves produced by some societal set of actions which necessarily precede any therapeutic encounter. For example, the identification of "therapists" as the appropriate social-professional category for knowing about personal misery or distress is itself a product of power's cultural and historical interaction with knowledge (similar to historical processes through which medicine became stamped as the discursive bearer of "truth" about the human body and the physical health of the population) (c.f., Butchart, 1997; Foucault, 1980; Rose, 1998; Sampson, 1989). Power can produce numerous subject positions for social participants (e.g., therapist and client), who are thereby shaped up in terms of the discourses to which power has become attached in that societal context. The local exercise of power in a therapeutic relationship must therefore itself be considered a product of a multiplicity of power relations and discourses that take place outside of, and which precede, any particular therapeutic relationship. An adequate analysis of power within therapy must therefore place therapist-client conduct within its broader discursive context.

A decontextualised account predisposes to power's concealment. Power cannot be adequately analysed if only its points of contact and realisation are addressed. We must do more than note power's intra-therapeutic effects; we must try to look at the whole ensemble of actions that made possible the production and in turn, the productivity, of those effects. A decontextualised account, and the practices associated with it, neglects the multiplicity of power

relations and discursive practices – circulating throughout society - that create the context for local exercises of power in a therapeutic (or any other) setting. The result is that power may superficially appear to be resolved at a local level (e.g., by labelling the work collaborative) even as it invisibly proceeds to organise the relationship and produce effects in the form of new knowledges and subject positions. Decontextualised accounts conceal the power features of therapy's effects, and make them invulnerable to critical scrutiny, except when they are considered abusive.

1.3.4. The interpretation of resistance

In the therapeutic literature, a client's "resistance" is overwhelmingly – but with some exceptions (see below) – interpreted as a process that is best understood in terms of the client's individuality, interiority or psychology. It tends not to feature as an issue when power in therapy is discussed; and when resistance is discussed, the concept of power is seldom raised. This is perhaps surprising given the seemingly self-evident observation that some people resist being subjected to exercises of power. Part of the reason for the failure to consider resistance in this apparently obvious, face-value way, is the therapeutic tendency to construct resistance in the terms of therapeutic knowledge. On the whole, therapists are encouraged to understand personal and interpersonal experiences (including resistance) in individualised, "interiorised" and psychological ways (Gergen, 1989; Rose, 1998), although in recent years there has been an increased recognition of the interpersonal elements involved (between therapist and client) in a client's displays of resistance (e.g., Anderson, 1997; Arkowitz, 2002).

I do not want to focus too much on various therapeutic views on what resistance is or is not, since that would detract from the specific issue of the relationship between power and resistance. It should be noted from the outset that my use of the term consists in the minimal (and yet defining) criterion that the client says "no", or refuses to participate in some activity proposed by the therapist (c.f., Foucault, 1997). To be clear, this is not all that resistance involves, but it is considered the defining starting point for all resistances to be examined in this work. In a therapeutic relationship, saying "no" (to the therapist) could be given meaning in myriad ways, and each therapist has a host of flexible, context-sensitive and situation-specific possible explanations for such conduct. It could be deemed evidence of a client's refusal to change, of his or her internal conflicts (c.f., Wachtel, 1982), "behavioural noncompliance" (Newman, 2002), ambivalence about change (Arkowitz, 2002), or even of the therapist's failure to establish a therapeutic dialogue, and follow the client's lead (Anderson, 1997).

On the whole it seems that authors in the therapeutic literature tend not to specifically or explicitly consider a client's resistance against the therapist to be a pointer to a therapeutic power relation that is *worth examining* (with a few exceptions – e.g., White, in Hoyt & Combs, 1996 – see also chapter 7). In some cases, it is examined for the therapist error it allegedly points to (e.g., Anderson, 1997, 2001). While such accounts are important in allowing critique of therapist activity, they do not permit a detailed investigation of how resistance and power might interface in ordinary therapeutic interactions. In most cases, therapeutic constructions of resistance do not facilitate, and perhaps even preclude, an

examination of therapist-client power relations. For example, resistance can only be evidence of "internal conflict" if there are discourses that construct it in that way. Psychoanalysis exemplifies this strategy, as it can be used to persuasively relocate interpersonal conflict between analyst and analysand into the intrapsychic domain of the analysand (e.g. Auld, Hyman & Rudzinski, 2005; Bateman & Holmes, 1995). Similarly, regarding resistance as ambivalence to change points to the need for the client to become aware of, and "understand and respect the reasons" for their resistance (Arkowitz, 2002, p. 224). As will be explored particularly in the discussion of psychoanalysis in chapter 7, such tactics distract from close scrutiny of the therapeutic power relationship insofar as resistance is not used - nor perhaps is it recognised - as an indicator of power.

And yet resistance is the *key* indicator of power. This relationship between resistance and power has been recognised by some authors and practitioners employing post-structural and narrative frameworks. Here, client resistances are seen as potential openings to new or not-yet-developed discourses of the self, which also are linked in with external, socio-cultural power processes (e.g., Byrne & McCarthy, 1999; Foote & Frank, 1999; White & Epston, 1990). On these accounts, resistances against the therapist may be taken as opportunities for the therapist to explore, with the client, the therapist's biases or prejudices (e.g., White, in Hoyt & Combs, 1996), and thus facilitate a move towards, even if never attaining, therapeutic democratisation. Some client actions may also be interpreted as resistances against prevailing sociocultural discourses and power relations – that is to say, they may be "externalised" rather than internalised – while the therapist aims to recognise and even support these resisting efforts (e.g., Madigan & Goldner, 1998; Nylund, 2002; Nylund & Ceske, 1997). These views will be critically discussed in chapter 8.

What is significant at this point is that many of these more critically oriented practitioners recognise the inextricability of power and resistance. Indeed, resistance is power's inevitable and omnipresent other. There can be no resistance without a power relation, and there can be no power relation without resistance. Foucault (1980) held that "resistances… are formed right at the point where relations of power might be exercised" (p. 142). It is significant that they co-exist, since resistance (of the face-value kind) is obvious and visible, while power works partly because it is hidden from view. The juxtapositioning of power and resistance is therefore methodologically propitious: it means that resistance can be used to make power visible, which thereby allows for an empirical, more or less precise identification of its points of application.

It should be noted that, according to Fish (1999), the relationship between power and resistance was underdeveloped in Foucault's work, and only emerged in the latter stages of his career, as he developed his notion of power away from the earlier focus on domination and the production of docility (e.g., 1977), towards an appreciation of the transformative capacities of resistance in a power relation (e.g., 1980, 1982, 1990). Indeed, in later works, Foucault considers historical change itself to be impossible without a dynamic interplay of power and resistance (Falzon, 1998).

1.4. Towards making power visible: Research questions and methods

Thus far, it has been argued that the difficulty in studying power is that its operations are frequently concealed. This concealment is, at the same time, one of the very reasons why power needs to be studied: its exposure promises to facilitate a more detailed understanding of its impact on the therapeutic relationship, but in a way that may also provide hypotheses about therapy's relationship with broader discursive, institutional, historical, social or cultural processes. I have tried to explicate four means by which power might be concealed, but we are left with the question: How are we to study power if, as I have argued, it is primarily invisible?

Certainly, we have clues from the preceding discussion: we need to consider power a productive, rather than repressive, set of forces, which serves to bring discourses, forms of talk, types of relationships, desires etc, into being. At the very least, this suggests that we are looking for something present rather than absent, something, in other words, that may be amenable to empirical examination. It is also suggested that power's effects (i.e., visible actions) be distinguished from power itself. This distinction encourages us to look at the conditions that make possible the practices that are visible, and produces vigilance around what actions might be concealed power effects. Furthermore, Foucault's work points us in the direction of knowledge: specifically, power and its effects may be discernible via the way in which knowledge – i.e., knowledge "about" therapy and the use of knowledge within therapy - is invoked and applied. And then, we need to also consider power in terms of the overall societal context in which the therapeutic relationship exists. But these guidelines are non-specific, in that they do not tell us where to start looking. Fortunately, resistance provides us with a key methodological tool in this regard: if we can take note of resistances, we have an immediate indicator of the specific sites of power's applications.

1.4.1. Overall research questions

Before exploring these methodological issues, it is important to note the questions around which they will be oriented. This thesis attempts to answer four basic questions.

1. What forces impact on participants in the therapeutic encounter?
2. How is power concealed in therapy?
3. How can power be made visible in therapy?
4. What is the relationship between therapeutic power and the operation of power at a societal-political level?

Each of the studies to follow (chapters 2-8) will address different aspects of these questions, and hopefully facilitate an expanded understanding of power mechanisms and processes in and around the therapeutic relationship. A summary of each chapter, and of their relationship to these questions, is offered in section 1.6 below. Further, I will offer tentative answers to these questions in chapter 9, drawing from the analyses and discussions of chapters 2-8.

1.4.2. Analysing discourse

With resistance identified as a prime tool for the recognition of power relations, and a series of questions noted, there remains the problem of analysis. Even if we can identify power via resistance, what methodological tools should be used for a detailed investigation of specific and local power relations? Foucault's work has been especially helpful in the construction of a theoretical framework, fashioned above to provide a set of guidelines for the investigation of power relations. But his genealogical form of historical analysis, designed to explore the way in which discourses intersect and engage in mutually strategic relations at a broad discursive (macro) level in specific historical "epistemes", probably provides too blunt an instrument for the analysis of the specific, local, nuanced and dynamic interactions that occur between therapist and client (c.f., Forrester, 2000). Indeed, McNay (1994) argues that Foucault's mode of analysis does not permit detailed examination of actual "power-in-action".

In order to address this problem, a discourse analytic method, primarily following Billig (e.g., 1996), Parker (e.g., 1992), and Potter and Wetherell (e.g., Potter, 1996; Potter & Wetherell, 1987), is suggested as a means by which to initiate and facilitate the analysis of power relations in therapy. Analyses of discourse permit a detailed study of the subtleties of actual talk in use, and are deemed sufficiently sensitive to address, in a systematic way, the variable, nuanced and dynamic nature of therapy-talk interactions. This methodology considers talk a form of social action (rather than a means for linguistic representation), in which a variety of social effects may be achieved or produced (Parker, 1992; Potter & Wetherell, 1987). Talk, which is converted into text for analytic purposes, is seen as constructed through the variable employment of socially and culturally available discourses (or "interpretive repertoires" [Potter & Wetherell, 1987]), and as productive of further accounts, of new or revised discourses, and of a variety of subject positions for speakers.

In this work, the significance of talk is that it is considered to be the primary way in which power enters and is exercised in the therapeutic relationship. As already noted above, any local application of power is merely its terminus or ultimate destination (see also Foucault, 1980). But more than this, talk is the means by which therapeutic understanding and change is effected. It is especially privileged in the therapeutic relationship; it is therapy's primary method and technique. In this way, therapy can be distinguished from other "ways of knowing" the person, such as medical practice, where non-verbal methods and materially based technologies (e.g., stethoscopes, medicines) are intertwined with talk. This does not mean that medical talk cannot be subjected to discourse analyses; nor does it mean that material objects and artefacts (e.g., reports, degree certificates, clothing, and office design) do not link in with talk in the therapy setting. I am merely pointing to the prime, central and defining significance of actual talk in the therapeutic relationship, as the method for knowing and influencing the actions of another. Talk here is the primary means by which discourses are produced, reinforced, weakened or otherwise transformed in the therapeutic relationship.

Potter and Wetherell's (1987) system for the analysis of discourse facilitates the identification of the way in which a person's accounts of events are

constructed, and the functions these constructions serve in talk. These guidelines will be employed in the empirical studies of this work, but mostly as starting points, since they do not point specifically to three issues of importance in this thesis: (1) the way in which speakers *influence* each other's talk; (2) questions of subjectivity (c.f., Willig, 2001); and (3) the relationship between, on the one hand, talk occurring "within the text", and on the other hand, discourses and procedures of power that operate at the macro-societal level (i.e., which, as argued above, may be invisible in the text). I submit that these three issues need to be explicitly addressed to allow for an adequate view of power relations. Therefore, it is argued that Potter and Wetherell's account, while useful, needs to be supplemented. I will address each of these points in turn.

1.4.2.1. Analysing rhetoric

Firstly, we require an analytic tool that highlights not merely how talk is constructed and rendered functional, but the specific ways in which speakers (i.e., therapist and client) use these constructions to exert influence on each other, and to either accept or resist being influenced. Therefore, in some of the studies presented (especially chapters 3, 4, 5 and 6), the idea of talk as *rhetoric*, or as argumentation (Billig, 1990, 1996), will be utilised. Rhetorically oriented discourse analyses allow us to consider the strategic relations between discourses invoked or constructed in a conversation. We are thus afforded a view not only of the way in which participants invoke and construct discourses, but also of the ways in which different discourses interact strategically with each other, to position participants in changeable and dynamic ways relative to each other. Following Billig, talk is seen to consist in processes of argumentation, in which discourses compete, and sometimes combine with each other, to undermine or otherwise transform other discourses: subject positions for social participants are thereby established or transformed.

It should be noted that while rhetorically oriented analyses are used here, Billig specifically argued that Foucault's work was inconsistent with rhetorical studies. He maintained that in Foucault's work, "discourses operate to obliterate argument in the interests of domination" (Billig, 1996, p. 14). Therefore, Billig continues, opposition "becomes unthinkable" (p. 14.). Such a view of power is inconsistent with rhetorical analyses, which have argumentation at their centre. Indeed, Foucault's earlier work (e.g., 1977) emphasised power as domination, and he saw the subjects of power as docile and compliant: argument cannot enter the frame here. As mentioned above, however, in more recent work, Foucault (perhaps less than explicitly, and sometimes inconsistently [Fish, 1999; Hindess, 1996]) paid increasing, though sporadic and underdeveloped, attention to the possibilities of resistance to power. In this thesis, this embryonic construal of the power/resistance relationship will be emphasised and developed. Specifically, the interplay of resistance and power in therapy talk is seen as empirically examinable *through* the notion of argumentation or rhetoric. Indeed, Falzon interprets Foucault's work as embracing a "dialogical ethics" (1998, p. 64), through which it becomes possible to study the dialogical interplay of forces implicit in all human interaction. This is inconsistent with the view of discourse as totalising domination that Billig accuses Foucault of holding. Argumentation, in this reformulation of

power, is not obliterated, but may be regarded as one of the very means by which power and resistance are given form and practised in talk. Thus, despite Billig's warning, I employ and highlight rhetorical analyses here as a methodological aid for making visible the dynamic interplay between power and resistance in therapy.

1.4.2.2. Analysing subjectivity

In exploring the use of specific discourses in the therapeutic relationship, I will not draw on a priori internalised or psychological accounts of desire or personal motivation. I aim as far as possible, in a manner consistent with Foucault's account, to make no assumptions about human subjectivity (Florence, 1998). However, it will be argued that subjectivity can be produced via the application of discourse to the self, generating a "conscience or self-knowledge" (Foucault, 1982, p. 212). Foucault (1997) indicates, however, that this is a self-oriented application of discourses that are available in the wider culture, rather than the emergent product of self-contained psychological processes. Thus, in chapter 5, I will examine the way in which a therapy client can come to apply therapeutic knowledge to herself, with the therapist's assistance (and that of a multitude of silent others), to produce a psychologised form of subjectivity, or "self-knowledge".

1.4.2.3. Paying attention to context

But in order to adequately conceptualise power, it is necessary to consider rhetoric, the production of subjectivity, and indeed the local power relation itself, in terms of the wider societal network. Therefore, I will examine, as highlighted in the above discussion, power in its context, lest we fail to address the socio-cultural and institutional processes by which power becomes available in therapy in the first place. Thus, I supplement discursive and rhetorical analyses with Parker's (1992) recommendation that we study discourses in terms of the way they "are implicated in some way with the structure of institutions" (p. 17). He suggests that this is a radical form of analysis, which involves: "Identifying institutions which are reinforced when this or that discourse is used"; and identifying "institutions that are attacked or subverted when this or that discourse appears" (p. 17). Parker goes further, suggesting that we should also show "how a discourse connects with other discourses which sanction oppression" (p. 20). These guidelines will permeate this work because the issues to which they refer are considered essential to understanding power generally.

Thus, contrary to Potter and Wetherell's (1987) guidelines, I will frequently step "outside of the (specific) text" being analysed, in order to theoretically consider its links with social contextual processes. Parker's points highlight the need to explore the ways in which broader social, cultural, political and institutional discourses enter into the therapeutic conversation, in turn facilitating analyses of how the therapeutic conversation – and its discursive products and processes of "argumentation" - might "feed back" into these broader discursive processes.

1.5. The structure of this thesis

I proceed through the following broad sequence, which is broken down into two main parts: power in the therapeutic relationship and its relation to societal power dynamics (chapters 2-6); and the uses of therapy as a critical tool in relation to these macro networks and relations of power (chapters 7-8). It should be noted, however, and it will become evident, that these are not two distinct aspects of power, but should be seen as fundamentally intertwined.

- *Chapter 2: Exploring the relationship between power, knowledge and resistance in therapy*

Chapter 2 explores therapy as a power/knowledge network, by considering how knowledge may be used to conceal or disguise ethically problematic power relations through the establishment of the specific subject positions of therapist and client. It will be argued that therapist actions that are deemed appropriate and acceptable in therapeutic practice may not only be inappropriate but also disrespectful, invasive and unacceptable in other settings. The positioning of the therapist relative to the client establishes for the therapist an entitlement to act in these ways. But these entitlements fall away when speakers' subject positions are altered, highlighting the point that the power/knowledge association is not absolute and fixed. Power's operations in therapy will be made evident through a deconstructive methodology, in which interviewees (eight practising therapists) are asked to comment on differences between a therapeutic interaction, on the one hand, and an identical interaction taking place in a non-therapeutic setting. Analyses of their discourses are undertaken.

- *Chapter 3: Primary and secondary positions in the therapeutic power/knowledge network*

While chapter 2 poses the problem of therapeutic power/knowledge, chapter 3 offers an account of the formal, institutionalised and "primary" subject positions – of therapist and client - that stabilise and hold in place operations of therapeutic power/knowledge. This is a theoretical exploration of therapeutic applications of the concept of the "dialogical self" (e.g., Hermans, 2001; Hermans & Hermans-Jansen, 2004), but which also draws on small samples of empirical data to clarify the ways in which the primary positions of therapist and client structure how their interaction is to be understood, both by each other and by real or imagined analytic observers. The dialogical self is a useful concept with which to engage at this point, because it explicitly posits analyses of "self-positions" (as outlined by Hermans [e.g., 2001; Hermans & Kempens, 2003]) occupied by therapeutic participants (especially clients), which help to clarify the power/knowledge relationship. Under a discourse analytic framework, these self-positions are converted into positions in discourse (i.e., the subject positions discussed throughout this work) to the extent that they (1) are evident in speech, and (2) construct particular avenues of action and subjectivity for participants. However, this chapter attempts to distinguish, and indeed to characterise the relationship, between on the one hand, emergent "secondary" positions that are observable

from "within the text" (i.e., in therapists' and clients' speech), and on the other hand, the often invisible extra-textual "primary" positions – of therapist and client - that condition and lend shape to the more visible secondary positions made available to participants, and which furthermore organise participants' experiencing, and our readings, of the therapeutic text.

This notion of primary positions highlighted in chapters 2 and 3 will permeate the remainder of this work. It conveys the argument that while the systemic therapists were right to speak of mutual rather than unidirectional influence between therapist and client (as discussed above), the nature of this influence will likely systematically differ, both qualitatively and quantitatively, depending on whether one is positioned as a therapist or a client.

Chapters 4 and 5 build on the previous chapters as they both address the following in more depth: (1) the impact of power/knowledge (through the therapist) on the client's talk and subjectivity; and (2) the relationship between local practices of knowledge and power in therapy, on the one hand, and broader social, cultural and institutional power relations on the other.

- *Chapter 4: Rhetoric as a vehicle for therapeutic power/knowledge*

Chapter 4 investigates more explicitly the way in which the therapist's talk may be considered an exercise of power. It is proposed that power often functions through persuasive or rhetorical activity, designed to induce and promote certain kinds of talk, rather than others. It will be argued that therapists of most traditions favour a particular account of personhood, identified through the notion of "self-contained individualism", which forms the ideal and normative standard of personhood in contemporary western institutions (Sampson, 1989, 1993). The primary positioning of the therapist increases the likelihood that his or her account will be favoured and adopted in the ensuing talk. Rhetorical analyses of two family therapy sessions are conducted to explore these processes. While the therapist presents arguments for clients' speech and actions to be considered in self-contained terms, the persuasive processes involved are concealed by the apparently "natural", and seemingly self-evidently true status afforded individualism. Thus, change may be constructed (by both client and therapist) in terms of individual and psychological processes that the therapist "drew out", rather than in terms of dialogical processes of persuasion, or discursive shaping techniques. Therapy may, in the process, unwittingly function as an individualising technology: reproducing the self-contained individualism required in dominant western institutions and cultural practice.

- *Chapter 5: Power, discourse and the construction of subjectivity*

Chapter 5 takes the case of a constructionist-narrative intervention with a young bulimic woman, extending the discussion of chapter 4 in two main ways: First, it focuses on the ability of therapeutic power/knowledge, through rhetoric, to produce not just certain kinds of talk, but a corresponding subjectivity. The case is analysed with specific reference to the way in which therapy talk marginalizes and disqualifies her initial resistance, and eventually shapes her view of herself and her eating behaviour in terms of a psychologized self-containment discourse.

These shaping procedures become obscured from view to the extent that her new ways of talking about herself are considered in terms of an emerging "self-knowledge". Her need for continued resistance is thereby obviated, and her potential critique of therapy is neutralised.

Secondly, this study questions the pathways through which such psychologization has become possible. It is noted that a political-feminist (as opposed to an individualised, self-containment) discourse could have been used in this case, but that therapeutic and psychological discourses and practices (including feminist-*therapy*) may have neutralised feminism's potentials to adequately account for eating disordered behaviour. This study emphasises that the priority given psychological discourse in therapy involves the subversion of other discursive possibilities, such as the client's account or a politically oriented feminist account. Attention is given to the means by which both feminism (at a macro level) and the client's discourses associated with her resistance (at a local level) are undermined, in order to make salient therapy's strategic-political engagement with alternative discourses that are culturally available.

- *Chapter 6: The possibility of therapeutic "non-power": The case of dialogical therapy*

Chapter 6 considers a counter-argument to the notion of therapy as a power/knowledge complex that has been supported in previous chapters. This chapter investigates the possibility of therapy without power, through the therapist's de-emphasis on expert and professional knowledge. Specifically, the dialogically oriented work of Anderson and Goolishian (Anderson, 1997, 2001; Anderson & Goolishian, 1988, 1990) is examined. This chapter considers their theoretical account, together with a series of conversational data, and questions the extent to which power can be considered a "non-problem" in this form of therapy, as they claim. Through an analysis of a case extract (presented by Anderson [1997]), it is argued that dialogical therapies evince what will be referred to as "special speaking arrangements", which provide evidence, not of power's absence, but of power's *pervasive presence* in the therapeutic conversation presented. It is acknowledged that this power is not realised through the degree of persuasive or rhetorical activity shown especially in chapters 3, 4 and 5, and its subtlety makes it more challenging to notice.

As highlighted in earlier chapters, power is to be found once again in the primary positioning – of therapist and client - afforded participants. And it is here that the challenge to the power/knowledge argument becomes especially instructive. That is, power works even in these collaborative, dialogical therapies – as it does in other therapies - to position therapists and clients differently, producing for the client a position of vulnerability with respect to exercises of power that *may or may not* be put into operation by the therapist. That the client has little choice with respect to how the therapist chooses to work (e.g., to impose or not impose interpretations) is precisely the source of his or her exposure and vulnerability. The power that Anderson (2001) denies is thereby exposed, although her disciplined refusal to actively exercise it (even though it is nevertheless *exercised*) is noted as a significant break from more subjectifying, knowing forms of therapy.

While the relationship between micro therapeutic practices and macro societal power arrangements are discussed in the previous chapters, chapters 7 and 8 focus more explicitly on therapy's ability to effectively challenge those institutionalised practices that are deemed oppressive, marginalizing, divisive, or subjectifying. Specifically, two sets of claims regarding therapy's ability to function critically, or to challenge systems of domination, are considered: (1) Habermas' (1972/1987) claim that psychoanalysis is an emancipatory practice; and (2) the claim that narrative therapy is a form of what Monk and Gehart (2003) call "sociopolitical activism" (p. 19). Previously discussed notions of primary and secondary positioning, the role of knowledge in therapeutic power, the phenomenon of client resistance, and therapeutic power as part of the overall societal diagram of power (i.e., power in context), are all brought forward into these chapters.

- *Chapter 7: Psychoanalysis: A critical engagement with Habermas*

Chapter 7 poses the question of a critical psychoanalysis by exploring Habermas' (1972/ 1987) claims for its emancipatory potentials. It is argued that Habermas attempts to situate critique – and hence, psychoanalysis - externally in relation to the systems of power he wants it to challenge. That is, he effectively positions psychoanalysis outside of the "diagram of power": outside of the societal network within which this thesis argues all clinical work must be contextualised. It is argued therefore that Habermas' vision for "therapeutic critique" is both theoretically and empirically untenable.

Instead, I outline an "internalist" perspective, in terms of which any critical practice must construct for itself a committed and transparent location within – and not outside of – networks of power. The possibilities of a critical psychoanalysis are then considered from that perspective. It is suggested that psychoanalysis' historically evident "spreading" across the political spectrum may be partly the result of its Habermas-like attempt to operate externally in relation to power. Its attempted theoretical independence from the societal network (i.e., its decontextualization) has made it vulnerable to being absorbed into non-psychoanalytic strategies, which have claimed, adapted and utilised its politically "free-floating" concepts and practices to enhance specific but diverse political objectives. Like narrative therapy, to be discussed in the following chapter, psychoanalysis thus becomes politically indeterminate: vulnerable to being used to support any number of (conservative or critical) political aims.

Out of these considerations, three tasks are suggested for a critical therapeutic practice: (1) taking note of resistance as a critique of power; (2) taking a stand and declaring one's own strategic positions; and (3) demonstrating reflexive responsivity to changing social, cultural, historical and political conditions. It is proposed that by taking account of these tasks, a clinical practice that aims to be critical – as is evident in the work of certain psychoanalysts - might move towards protecting itself from political usurpation, and be sufficiently adaptable to allow it to remain in touch with the constantly changing agenda for the critique of power.

- *Chapter 8: Narrative therapy and the possibility of critical therapeutic practice*

Chapter 8 considers narrative therapy's participation in systems of power. In contrast to psychoanalysis' political variability (as noted in chapter 7), narrative therapy has attempted to explicitly and consistently position itself as a critical and even subversive practice in the overall diagram of societal power. Many narrative therapists have adopted an explicitly Foucaultian view of power: they consider power in its productive (rather than repressive) aspect; they take note of power and resistance as contextual phenomena; and their formulations are also – unlike most other therapies - capable of theorising the *direct* and fundamentally interconnected relationship between power and resistance.

But despite this cautious theorising, and explicit political positioning, narrative therapy faces some of the same dangers facing psychoanalysis, as elaborated in the previous chapter. As it becomes more popular, narrative therapy risks becoming integrated – partly through an eclectic mixing with other therapies - with the very sociocultural systems of power to which it is opposed. Aspects of the capturing capacities of the overall diagram of power in which narrative therapists find themselves are elucidated in this chapter. This discussion also uses the concept of primary positions to raise ethical concerns about the use of therapy for critical ends. Narrative therapy is inevitably itself just another version of a power/knowledge complex (as outlined especially in chapters 2-5). Thus any promotion of societal critique must take into account the effects of power associated with the therapist's primary position relative to the client. Certain power effects of this positioning are considered universal in therapeutic practice. Therefore, an overtly critical therapy, such as the narrative approach, may involve as much client objectification and subjectification as seems evident in more conservative, conformist or allegedly apolitical therapeutic endeavours. Though it is sensitive to the dangers of power, via its (partly) Foucaultian theoretical base, it seems that narrative therapy cannot avoid operating as a power/knowledge complex, and thus may itself contribute to the maintenance of the very problem of power that it tries to undermine.

- *Chapter 9: Integrative summary and discussion*

In chapter 9, I summarise and attempt to integrate my arguments and the conclusions of the preceding studies in the form of answers to the overall questions posed above (in section 1.4.1.). In that discussion I offer suggestions for future research and study, and then discuss some limitations of the studies presented in this thesis.

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CHAPTER TWO
EXPLORING THE RELATIONSHIP BETWEEN POWER, KNOWLEDGE AND RESISTANCE IN THERAPY [1]

2.1. Introduction

The concealment of power can be achieved in many ways. It is not necessarily the product of political will, personal intent or conscious design, but is an inevitable feature of the requirement that in order to be actualised and exercised, power needs to become bound up with some structure or form. Consequently, it is the form that power takes, the structures with which it becomes enmeshed – rather than power itself - that becomes more salient. Power operations are thereby rendered tolerable, and some its features are hidden from view (Foucault, 1990).

In this chapter, I consider the therapeutic relationship as a power/knowledge network, and examine how the meanings produced within therapy function to conceal the power aspect of the power/knowledge integration. I propose that the therapist-client power relation is facilitated by a particular kind of "incitement to discourse" (Foucault, 1990). That is, not only is therapy a situation in which meaning must be made; it is a situation in which meaning is produced, crucially, through the mechanism of a fixed and pre-constructed relational arrangement. The designated therapist is culturally and professionally granted an entitlement to construct meaning around any or all of a client's conduct; even, as shall be demonstrated, when the client objects. The risk is that the other who is the client thereby becomes an object of therapeutic discourse, and hence vulnerable to shaping in its terms. And yet to observers, and perhaps also to participants, it seems not that the client is being shaped through mechanisms of power, but that he or she is merely being *recognised* or uncovered through the deployment of accepted therapeutic knowledge forms.

But this is not only about the overt imposition of meaning. As noted in chapter 1, increasing numbers of therapists are critical of practices in which therapeutic interpretations are imposed on clients in authoritarian or hierarchical ways (e.g., Anderson, 1997, 2001; Hoffman, 1992; Tomm, 1994; Totton, 2000). However, this study suggests that the imposition of meaning is not necessarily the product of an authoritarian or directive approach, and may not even be effectively countered by a therapist's ethical or egalitarian intentions (c.f., Goldner, 1993), but may instead occur through the interactive processes associated with the very basic therapeutic requirement that a client's actions *be understood*; processed through some or other discursive framework. And yet, this lending of meaning to a client's actions helps to conceal power relations and tactics that are inherent in the relationship.

I begin with a theoretical proposal for the construction of therapy as a power/knowledge network. The significance of resistance within this network will then be considered, before moving on to an empirical study designed to elicit and render visible aspects of the interactions between power, knowledge and resistance.

[1] Chapter based on: Guilfoyle, M. (2002). Power, knowledge and resistance in therapy: Exploring links between discourse and materiality. *International Journal of Psychotherapy*, 7 (1), 83-98.

2.2. Conceptual issues

2.2.1. Therapy as a power/knowledge network

As already noted, the relationship between knowledge and power has been explicitly or implicitly recognised by many authors and researchers of therapeutic practice (e.g., Andersen, 1987; Anderson & Goolishian, 1990; Bateson, 1979; Bird, 1994; Foote & Frank, 1999). Therapists attempting to construct a postmodern form of practice have argued against the use of knowledges that objectify the client and construct him or her as a knowledge object (e.g., Amundson & Stewart, 1993; Carpenter, 1994; Hoffman, 1992). Attempts have been made to avoid the mystification of therapy and of the therapist, and to reduce the apparently hierarchical relationship between therapist and client, through more transparent and collaborative language practices (e.g., Anderson, 1997; Goldberg, 2001; Hoffman, 1992; Simon, 1993). Some have tried to remove professional knowledge (i.e., content knowledge, through which the client becomes knowable) from the therapeutic arena altogether, in an open attempt to remove the problem of power (e.g., Anderson & Goolishian, 1988, 1990). And in an alternative effort at democratisation, Sandor Ferenczi, an early psychoanalyst and friend of Freud, encouraged one of his clients (or analysand) to alternate positions with him in a "mutual analysis", so that she could also subject him to analysis (Totton, 2000; Yalom, 2002). Ferenczi reasoned that mutual self-disclosure and the sharing of knowledge applications would help equalise the power relationship.

The difficulty with knowledge, as recognised by many of the above-mentioned authors, is that it can serve as a vehicle through which power is exercised. The question of the extent to which knowledge, and hence power, can be put aside in therapy (e.g., Anderson, 1997, 2001; Anderson & Goolishian, 1988, 1990), will not be specifically addressed here (see instead, chapter 6). Rather, focus falls at this point on the ways in which knowledge is or can be used by a therapist, and on its relationship with power. First, the power associated with the wide range of therapeutic knowledges must be briefly considered in its social and discursive context. However, a note of caution is necessary: this context is not merely a contextual backdrop, a ground against which the figure of power can be discerned; it is *part of* the way power works in therapy, and should be included in its definition. The danger is that if it is not considered this way, power can be seen as a localised phenomenon. The matter of extra-therapeutic context will only be touched on here, in order to mark its significance, but will be further elaborated in subsequent chapters.

2.2.1.1. The context of therapeutic practice

Rose (1998) has underscored the significance of therapeutic languages in the process of the individualisation of contemporary western persons, a process which inscribes people with an interior, psychological world, and "types" of individuality, personality, and bodies (Burman, Aitken, Alldred, et al, 1996). Therapeutic knowledge – its languages and technologies - has become a widespread tool for making sense of oneself, of others, and of one's relationships with others, in a

variety of settings: the family and child-rearing (Burman et al, 1996), businesses, factories, schools, as well as medical, legal and political systems (Rose, 1998), and throughout the media (e.g., agony columns and television talk shows). Each of these institutions and practices favour accounts of the person as an individual, as a more or less calculable and knowable entity, responsible and accountable for his or her actions, but also as self-contained: imbued with personal and interior psychological qualities and processes, and demarcated as separate and distinct from other persons (Sampson, 1993). With such individualism so pervasively marked, people in contemporary western societies have become well able to understand and construct themselves as psychological beings, for whom psychological and therapeutic accounts of behaviour can easily become meaningful and practicable.

The significance of therapeutic *practice* is that it is, I suggest, one of the sites in which specialised knowledge of the person is most intensely, most intimately and most systematically applied (other specialised sites that inscribe individualism include the doctor's office and the confessional). The therapist is the embodiment of this extensive and widespread therapeutic discourse, and his or her office is an intimate space for their application. Within this space, therapeutic knowledge is made productive (or "therapeutic") via its application, or distribution, to different aspects of a client's experience. According to Foucault (1980), however, knowledge in itself cannot be transformative; it cannot have productive effects on its objects (that which it delineates), unless it is fundamentally integrated with power. And so to the extent that knowledge is applied to the person - in this case, the client - we have to consider the simultaneous distribution of power. The reach of knowledge in relation to a client's experience (those parts of his or her life that knowledge is applied to) points us also to the reach of power (the ability to lend force to the shaping effects of knowledge on a client's experiences). By being able to touch on many aspects of a client's personal experience, therapy uses both knowledge and power to enhance its ability to shape a client's self-examination and subjectivity (Rose, 2001). And so, insofar as therapeutic knowledge and power are interrelated, there is merit in speaking of therapy as embodying a power/knowledge network.

2.2.1.2. The production of subject positions

Knowledge produces and reproduces power relations partly through the construction of "subject positions" (Willig, 1999). Therapeutic knowledge positions those designated as therapists in a very different way than those positioned as clients. The former is granted the status of expert-knower. Therapists personify – or embody – a kind of therapeutic gaze: visible, tangible representatives of a certain way of "looking at", or examining, the human being. The expert nature of this embodied gaze is evident, indeed advertised, in certain visible and material aspects of therapy: for example, being located in a clinic, alongside other socially recognised experts in similar or related fields, having degrees displayed on walls, having headed notepaper, etc. On the basis of this embodiment, therapists become socially and professionally entitled to freely ask questions, offer interpretations and make other interventions with regard to another's personal life. The therapist is positioned in therapeutic discourse as its practitioner, actively

selecting, utilising, modifying and perhaps judging the appropriateness and extent of applicability of the discourse in use. In this way, therapeutic discourse appears to give the therapist almost supra-discursive status: apparently (i.e., visibly) its controller, manager or master. And yet at the same time, this status is (though less visibly) undermined as she or he is required – in order to remain a therapist - to operate within its terms.

On the other hand, and in contrast, the client is afforded a complementary position of clienthood. It is significant that the person adopting that position thereby becomes a knowable entity which therapeutic discourse is designed to "fill out". Just as therapeutic expertise is embodied in the therapist, so the other's clienthood – she or he who is the object of, and becomes subject to, therapeutic expertise – is embodied and materialised in the person who sits opposite a therapist in the latter's office, perhaps paying fees, and being the subject of professional notes, referral letters and reports. Clients are positioned such that they are expected to answer questions and undertake a form of self-examination; to subject themselves to a therapeutic gaze, and to the discourses it uses to construct them. This gaze is distinct and partial, as it predisposes towards a particular kind of examination (i.e., a therapeutic examination, associated with a specifically therapeutic gaze) of one party (the client), but not the other.

The differentiation of these subject positions may seem overstated to the extent that, as indicated, earlier, an increasing number of therapists, of various orientations, attempt to work in respectful, reciprocal and collaborative ways, in which expertise and expert knowledge are not willingly imposed on clients. But Carpenter (1994) claims that even in the face of these attempts clients often feel "completely under … (the) control" of the therapist (p. 33). Similarly, Young, Saunders and Prentice et al (1997) maintain that in self-proclaimed collaborative therapies, in which therapists openly deny their apparent expertise, clients still continue to perceive their therapists as experts, even when therapy ends. The problem of power here lies not in any therapist's intentions to operate "as a power-crazed professional hungry to dominate and control… clients" (Carpenter, 1994, p. 33), but in the *discourses* that position therapists and clients differently, regardless of their respective intentions. Discourse, rather than intention, produces power relations (c.f., Goldner, 1993; Hare-Mustin, 1994; White & Epston, 1990). And so while some therapists may choose to position themselves in non-expert ways, this in no way precludes the *client* – and indeed, as discussed above, the rest of the community that forms both the client's and the therapist's social network - from positioning the therapist as a knowing-expert. The widespread cultural dispersal of therapeutic knowledge, and the host of discursive and material factors that install the therapist as the embodiment of this knowledge, make it entirely reasonable for the client to resist, or view with scepticism, the therapist's seemingly idiosyncratic claims to the contrary. Thus, therapists who attempt to deny their expertise, and who claim to have democratised therapy, risk being seen as disingenuous or at least unconvincing (Atkinson, 1993).

These complementary subject positions predispose to a therapist-client power relation, through which a route or course for power is established. The client is expected to apply therapeutic knowledge to him- or herself, while the therapist is constructed as the orchestrator or facilitator of this application. And to

the extent that this knowledge has an effect on the client's experience, we can say that it has been supplemented with power. That is, to the extent that the client applies this knowledge to his or her experience, we can say that she or he has become *subject* to it: it becomes the means through which his or her experiences, self, problems, and solutions are constructed (c.f., Foucault, 1982). Thus, power and knowledge work together – often regardless of the therapist's intentions - to articulate, structure and ultimately to transform the client's experience.

2.2.2. Resistance and power

In order to assess a therapist's socially negotiated entitlements to distribute, or apply therapeutic power/knowledge to another person's experience (either inside or outside of therapy), it is instructive to explore socially and professionally accepted strategies for dealing with that person's resistance. Resistance indicates a refusal of the application of therapeutic knowledge in certain areas of a person's experience, and correspondingly, a refusal of the therapeutic power supporting and supported by that knowledge. It proposes a limit to the therapeutic incitement to discourse; a limit to the reach of interpretation. In this sense, resistance should not be dismissed as an internal, psychological process, or even as a "pathologising concept" (Simon, 1993, p. 149), but as a specific response to power tactics in a power relation. Resistance is seen here purely as political action, the nature of which is hidden to the extent that it is interpreted as a psychological process (see also chapters 5 and 7). Further, Foucault argues that while power is frequently concealed, resistance is more visible. And because it is a response to power tactics, it can also make visible the points at which power is being exercised (Foucault, 1980). Resistance can thus usefully highlight power that might otherwise be concealed. It can also thereby provide a critique of our apparent entitlement within therapy to ask questions, offer suggestions, or comment on aspects of a client's life she or he prefers not to have touched by our knowledge. In order to see where therapeutic power might be a problem, client resistance is a good place to start.

Out of these considerations, the following key questions emerge: (1) What does therapeutic discourse, and the attendant complementary subject positions, entitle therapists to do when a client *refuses* therapeutic power/knowledge practices?; (2) What happens to such entitlements, and to the relationship, when therapists are dispossessed of their therapeutically inscribed subject position? The role of the therapist's discursive positioning in the application of therapeutic power/knowledge is under scrutiny here. That is, when *positioned* as expert, the therapist derives an entitlement to use therapeutic knowledge to construct meaning around resistance. But when not positioned this way, these entitlements fall away and his or her interventions may be rendered impotent, *because* in that instance the knowledge she or he embodies becomes divested of power. This seemingly self-evident distinction (between playing and not playing the role of therapist) is significant in that it can be – and will be below - used to highlight the power relations and series of power manoeuvres that may otherwise be hard to see in a therapeutic relationship.

I argue that if we look at the therapist's entitlements to exercise expert knowledge *outside* of therapy, we become able to assess the degree to which therapeutic knowledge and power may be separated, and divested of each other. In such extra-therapeutic settings, the attempt to exercise therapeutic knowledge – e.g., to make interpretations, or ask probing questions – may be more easily discounted, disqualified or minimised by recipients. That is, our knowledge becomes detached from the legitimised forms of power to which we have access within a therapy setting. However, on the other hand, within therapy, power's participation in the construction and reproduction of distinct subject positions works to minimise such dismissal. The point is that if we respect a person's dismissal of our "therapeutically" probing statements outside of therapy (and I will demonstrate that it is our custom to do so), we need to carefully consider how we deal with such dismissals by clients *within* therapy. If we compare the dynamics of knowledge, power and resistance across settings, we may be afforded a view of our therapeutic actions – specifically with regard to resistance – as somewhat disrespectful, even though we might construct these actions as acceptable, appropriate, and perhaps necessary, through some version of therapeutic discourse.

2.3. Methodology

I attempt to address these questions by constructing two discursively identical, but situationally different hypothetical situations, in which a power relation is being played out: one conversation taking place in the context of therapy, and the other in a more business-like context. Eight practising therapists consented to being individually interviewed for this study, and they were each presented with the two case-scenarios, in the following sequence: scenario 1 was presented, and discussion invited, and then scenario 2 was presented, followed by further discussion (elaborated below). Since interviewees' verbatim comments are to be offered below, their names have been changed for the presentation.

Scenario 1

> Mary is a psychologist, who has been seeing Steve for the depression he's been suffering. They have arranged regular sessions, but Steve has been arriving late for the last few meetings. At first, Mary doesn't say anything about it. When it happens for the third time, however, she decides to raise the issue with Steve. The following interaction takes place:
>
> Mary: Steve, I've noticed that you've arrived here quite late for the last few meetings.
> Steve: Yeah, I'm sorry about that, I didn't mean to inconvenience you… (3 second pause). Let's get down to work shall we?
> Mary: Well, sure, but maybe its relevant to what we do here, if only because it means that at the moment we have less time to discuss other important things.
> Steve: Um… okay, if you feel it's that important.

Mary: I do think it's important. Is there something troubling you about these meetings?

Steve: No, its just something going on at home, which I'd rather not get into here if that's okay? I won't be late again.

Mary: Okay, sure that makes sense. I was wondering though that if we could talk about that, would it make our work here move along better?

Steve: Mary, look. Thanks for your concern, and I appreciate you trying to move things along, but as I said, I don't want to talk about it alright? I
will make every effort to be here on time. Problem solved. Can we just get down to the business at hand here?

Interviewees were asked to comment on the following: Mary's behaviour; Steve's behaviour; and the apparent difference of opinion between them regarding the relevance of Steve's difficulties at home, and his being late, to therapy and to the problem of "depression". Interviewees were asked how they would address these issues in therapy. Following these commentaries, scenario 2 was presented, of a "business meeting", but with identical dialogue to that of scenario 1. The outline of the case was offered as follows:

Scenario 2

> Mary, a psychologist, and Paul, a lawyer, are involved in writing a book together. They have arranged regular meetings to discuss the intricacies of the book, but Paul has been arriving late for the last few meetings. At first, Mary doesn't say anything about it. When it happens for the third time, however, she decides to raise the issue with Paul.

The exact same interaction offered in scenario 1 was presented with scenario 2, substituting "Paul" for "Steve". Participants were then asked to comment on the interaction; on Mary's behaviour; Paul's behaviour; and then to discuss any perceived similarities or differences between the two settings.

These scenarios depict a person (Steve/Paul) refusing to speak beyond a certain point. I shall refer to this as resistance. My interest lies in interviewee's constructions of what is considered reasonable for the therapist to say and do in response, in the respective situations. In order to analyse the transcribed interviews, I begin by exploring the ways in which versions of events are constructed, and the variation evident in these constructions (following Potter & Wetherell, 1987). Thus my initial questions are: How do interviewees construct these respective resistances, and what variation can be detected in these constructions? It is proposed that there may be a level at which this variation is homogenised within settings, and that the discourses for the therapy scenario will systematically differ from those offered for the business scenario. Thus we might be able to ascertain the degree to which it is deemed appropriate and reasonable to apply and distribute "therapeutic" statements in one setting as opposed to the other, and further, assess these applications in terms of the degree of respect they afford clients or business colleagues, respectively.

A final note about methodology: because discourse analytic studies tend to be critical, interviewees risk being portrayed in a rather negative light. I therefore want to emphasise that comments elicited from interviewees in this study are seen to be consistent with a range of accepted theoretical and practical guidelines for therapeutic practice. My critique falls not on the specific responses elicited from interviewees, but focuses on the reification and institutionalisation of therapeutic discourse and practice that makes these responses (in all their diversity) possible and acceptable.

2.4. Analysis

2.4.1. Constructing therapeutic knowledge

In order to establish a focus on power and resistance in therapy, it is first necessary to acknowledge the wide range of knowledge systems of client behaviour that therapists have access to, since each of these produces potentially different sets of power relations (Rose, 2001). Variations in this regard are therefore to be expected in interviewees' accounts of the two scenarios.

Some interviewees expressed reservations about the therapist's approach with Steve (her client in scenario 1). Her actions were variously constructed as "therapeutically clumsy" (Tom), "probing too much" (Maura), "pushing him a bit too far" (Eve), and "school teacher-ish" (Martine). On the other hand, Mark felt she'd been "appropriate", while Denise considered her approach "textbook". This issue is worth noting merely to indicate that there was disagreement regarding whether or not this was an example of good therapy.

Nevertheless, there was agreement that it was appropriate for the therapist to be interested in exploring issues beyond Steve's depression. It was considered reasonable to interpret even those areas Steve refused to discuss. In this regard, various ideas were offered for making sense of these issues, indicating some of the ways in which knowledge can be brought to bear on aspects of Steve's behaviour:

Extract 1

Maura: It could be… that there's something going on at home is a result of his depression, rather than ya you know, being um a cause of the depression… it could be either way around.

Extract 2

Tracy: The depression might be the outward problem, and he thinks that's the problem, but obviously what's going on at home is also related to it in some way.

Extract 3

Martine: The man being late could be something to do with him being depressed and he finds it hard to get up and get going, so that could be part of em that information could assist her in in helping him, he's come in looking for help… I think perhaps what she's trying to do is explore

different possibilities.

Extract 4

Mark: His being late may be a manifestation of an issue that's hard for him to just talk about openly, so he acts it out instead. He's avoiding revealing important, maybe threatening things about himself… What goes on at home is a very important part of his life, or anyone's life, and so it probably is relevant to his depression, to the way he deals with people and the way he deals with the world. I mean he's … telling the therapist to back off a bit, and that may tell us something about the way he copes with stress, with life, with people, or even with exploring himself.

From these statements, we can discern at least three different constructions, which can establish different therapeutic priorities:

1. *Depression as an "outward problem", a "manifestation" of other issues*. This discourse prioritises the non-outward or non-manifest realm, in which issues such as "what's going on at home", or other "threatening things about himself" (Extract 4) may lie. Maura also hints at this possibility, suggesting that the causal link between depression and Steve's home situation "could be either way around" (Extract 1). Depression may be an effect rather than a cause.
2. *Depression as part of an avoidant life strategy*. The client may be constructed as avoiding "threatening things", an avoidance that can tell us about how he "deals with people and … the world", "copes with stress", and which might also inform us about his "depression" and "the way he copes with… exploring himself" (Extract 4). The discursive priority here might be something like the life strategy of the client.
3. *Depression as causing other problems*. Here, depression itself becomes the priority. For example, Martine suggests that depression may lead to the client finding "it hard to get up and get going", leading to his being late (Extract 3). Maura suggested that "something going on at home" could be "a result of his depression" (Extract 1).

These constructions exemplify ways in which therapeutic statements can be arranged, distributed to, and made to impact on, different aspects of a client's life (e.g., his depression, being late, home situation, life strategy, or non-manifest experience). However, in order to make more apparent the extent of this distribution, and the therapeutic assumption of an entitlement to effect such applications, it is useful to contrast this situation with what interviewees consider reasonable to say and do in the business setting.

2.4.2. Contrasting talk of therapy clients and business colleagues

Reservations were even more strongly expressed about Mary's tactics in the business setting, in comparison with the therapy setting. There was also a systematic distinction made by interviewees between these two settings, in terms

of the appropriateness or reasonableness of her interest in areas beyond the "business at hand" (solving depression/ writing a book). The distinctions made between the two settings point us to different constructions about what is considered a reasonable intervention in one setting as opposed to another. The following statements refer to these differences.

Extract 5

Interviewer: (Referring to scenario 2) What do you make of his final response?

Eve: Ya, it's certainly far more appropriate I think than in the last one (scenario 1). (In scenario 2) I think that's quite appropriate I'll make an effort to be on time and let's get down to the business at hand, I think that's quite professional and that's the kind of relationship they seem to be having, it's quite appropriate…. She is very intrusive (in scenario 2)… its not her business to get into his personal life if they're working on something together, whereas in the other situation (scenario 1) they are dealing with things more on a personal level again… I mean (in scenario 2) she's not going to talk to Paul about his depression and his personal difficulties, because its not that kind of relationship, whereas in the first one they are they're in therapy together… I suppose she's allowed to ask more personal questions isn't she.

Extract 6

Tracy: (Scenario 1) She sees it as blocking their work em because he's arriving late so its causing problems, not just for him, for their work together em he's getting less of a session… he's blocking himself in a way, you know, his home life is obviously a problem, and he doesn't want to talk about it so, if he doesn't want to talk about that it can't be solved. That's a problem… (In scenario 2) He just wants to do his work and that he'll keep his personal life out of work em… I don't think she has any right to go into his personal life… I'd tell her to focus on the problem and not the cause of it… she has the right to correct him and to sit down and try'n work out a solution, um but only around his work, not his personal life.

Extract 7

Maura: There's a difference in how far you should probe a person for information when there's no, um, its not of benefit to the person, and (in scenario 2) its obvious that he doesn't want to discuss it… Here (scenario 1) she was probing, you know, but I means that's still for his benefit, she's doing that, she might be making the wrong decision to be going that far, but it's it's for his benefit, whereas here (scenario 2) um I, its of no benefit to him really to know why he's why he's late.

As a therapist, Mary is granted the right to be interested in matters Steve wanted to avoid discussing. The point is made that, as opposed to a business setting, the therapist is "allowed to ask more personal questions" (Extract 5)

when positioned as a therapist in a therapeutic relationship. The discussion of these personal issues is seen as "for his benefit" (Extract 7), and as a possible solution to the way in which the client is "blocking himself" (Extract 6). In other words, therapeutic access to a client's personal information is considered important in therapy, without which problems "can't be solved" (Extract 6). As already indicated by Martine (Extract 3) access to such information may yield important information for the therapist. In the therapy setting then, it is considered reasonable and necessary for the therapist to construct and apply therapeutic knowledge to the client's life. In this way, it is "reified" (Potter & Wetherell, 1987): made relevant, real and practicable for and with the person positioned as client.

In contrast, the entitlement to express such interest is sharply restricted in the business setting. Mary is afforded the right to "work out a solution… but only around his work, not his personal life" (Extract 6). His personal life is seen as "not her business" (Extract 5), and its discussion deemed "of no benefit to the person" (Extract 7). His refusal to discuss it is therefore seen as "appropriate" to "the kind of relationship they seem to be having" (Extract 5). Interviewees see the business colleague's resistance as reasonable, and so they discursively "ironise" (Potter, 1996), or make less real and less relevant, the relation between this person and therapeutic knowledge.

It is considered reasonable to distribute therapeutic statements much further in relation to someone positioned as a therapy client than with someone positioned as a business colleague. Given that knowledge and power are fundamentally interconnected, this distinction has important implications for the exercise of power in the two settings, as well as for the respective constructions and strategies for dealing with resistance.

2.4.3. Constructing resistance

Both Steve (the therapy client) and Paul (the business colleague) demonstrated resistance to the distribution of therapeutic knowledge to various aspects of their "personal lives". Having established that interviewees' spoke of Paul's resistance as "appropriate" to the "relationship they seem to be having" (Extract 5), I will focus here on statements made in reference to the therapy client's resistance:

Extract 8

Martine: I guess he is he's trying to avoid whatever it is they wants to be discussed… (the therapist needs to) build the warmth in the relationship.

Extract 9

Eve: I'm not sure he thinks it's not relevant (i.e., his home situation), I just think he's not ready to talk about it yet.

Extract 10

Maura: (At the point of resistance) I'd leave it maybe for a while and go on to possibly uh more educating him regarding causes of depression or possible um things that are related to depression… I think he's not

ready obviously at this stage to talk about it really, but it may give him something to um mull over during the week if you give him more insight into the possible causes of depression and what may be related to it.

Extract 11

Tom: I see it as really an interpersonal wrestling for who defines the awkwardness between them and around the lateness… it seems to comment on how safe he feels in the relationship.

At this point I want to highlight simply *that* the therapy client's resistance is "worked up", turned into therapeutically accessible meaning (as opposed to the business setting). Certainly, this may be done in various ways, in accordance with different therapeutic approaches, and with different consequences for action. For example, understanding resistance as not being "ready" to talk (Extracts 9 and 10) suggests that Steve could *become* ready at some future point, either through therapist interventions (e.g., by building the "warmth in the relationship" [Extract 8]; by "educating him regarding causes of depression" [Extract 10]), and/or through the client's own work on himself (e.g., "it may give him something to mull over during the week" [Extract 10]). If on the other hand, the client's resistance is a feature of "interpersonal wrestling" or a "comment on how safe he feels in the relationship" (Extract 11), it becomes relevant to therapy insofar as it provides a kind of diagnosis of what's wrong, and points to possible solutions (i.e., improve certain aspects of the relationship). The point is that resistance is rendered meaningful, and put into discursive form.

One interviewee maintained that she would consider *not* proceeding beyond the client's resistance, but that this decision depended on the therapist's assessment of certain issues. She speaks here of the decision to discuss or not discuss the client's home situation.

Extract 12

Denise: I suppose (discussing) it would be important on lots of levels… Perhaps what is going on at home for Steve is important but he's not at a point where he wants to bring it up in therapy… My sense would be to say is the work that they're doing productive? If it is then maybe she needs to leave it because that's his choice really… (It) depends on the context of what it is that they're discussing and the kind of relationship that they have. It depends on whether his depression is about his home setting, or maybe it's work, but it would depend really… I might leave it for quite a while especially if he was getting hot about it.

Thus, therapeutic knowledge is used to decide on the relevance of Steve's home situation to the discussion. Despite Steve's protest against this issue being rendered accessible to therapeutic exploration, the interviewee proposes that its relevance (and the need for discussion) "depends" on many factors. While it might not be immediately discussed, its significance and relevance is established not by Steve's preferences, but by the expert therapeutic considerations of the therapist.

Interestingly, no such conditions are attached to an acceptance of the business colleague's refusal. He is not even expected, in the eyes of interviewees, to define what resistance means for him. It seems reasonable to leave it untouched, simply because he said so. His resistance is respected, and its possible meaning is simply dismissed as irrelevant, because it isn't any of Mary's business in the first place (Extract 5): she has no "right to go into his personal life" (Extract 6). The lawyer in a collegial situation is not seen as a site upon which therapy knowledge can or should be positioned, and it does not seem reasonable to turn his resistances against such efforts into discourse.

On the other hand, the transformation of not just the client's talk, but also his *resistance* to talk, into therapeutic knowledge is made to appear reasonable in the therapeutic setting. While there may be some flexibility around how this resistance is constructed, the expectation that it should nevertheless be constructed or "worked up" in some way becomes evident. Knowledge, in other words, is used to fashion what the client attempts to keep outside of therapeutic shaping processes. This extension of knowledge, to areas where it was initially refused access, assumes and reproduces a power relation between therapist and client, in which a client's protests can be neutralised, his or her proposed discursive limits breached, and all in such a way that it appears reasonable, appropriate or acceptable. And yet behaving in such a way with a business colleague is considered unreasonable, inappropriate and disrespectful.

2.5. Discussion

The adoption of the position of therapist within a therapeutic discourse carries with it the presumption of a power relation with another, designated the client. The initial challenge facing us in this regard is one of recognition: how do we know when power is being exercised? I argue here, along with others (e.g., Bird, 1994; Carpenter, 1994; Hoffman, 1992), that power is exercised through the construction of the client as an object of therapeutic knowledge, in relation to which the therapist is positioned as knowledge's practitioner, its embodied representative, and seemingly its controller, manager and master. The assumption of this position, and the entitlements that are constructed in the process, become especially salient when the matter of client resistance is raised. And so this chapter further suggests that when the client says "no", the therapist derives a warrant to overcome, interpret, psychologise or even ignore this resistance: to use therapeutic knowledge to remove refusal from its interpersonal, political dimensions, and place it, in one way or another, within the domain of therapeutic discourse. And thus, because resistance points to power, the latter may be obscured via the concealment (through the reinterpretation) of the former.

There is an "incitement to discourse" inherent in therapy (c.f., Foucault, 1990). Whatever occurs within that setting can become the subject of therapeutic discourse (of whatever variety) and a therapeutic gaze. Kogan and Brown (1998) have used this concept to understand therapy as a "specific form of subjectivity 'machine' where (a client's) experience is rendered meaningful" (p. 499). The very idea that a person can be understood positions him or her within an observing discourse and produces power relations and effects (Foucault, 1988).

Therapy involves an intensity of observation and a relentless pursuit of meaning that is focussed exclusively on the client. A power relationship is produced in which therapists become entitled (by virtue of their expert position within therapeutic discourse) to create meaning out of the client's conduct, and to allow this meaning to influence the interaction; even when (and for some, *especially* when – Messer [2002]) the client explicitly requests that this not be done.

This process (constructing meaning which informs the interaction) may be conducted in apparently benign or seemingly respectful ways, and does not necessarily involve the therapist's authoritative imposition, on the client, of any particular interpretations. As has been shown in the analysis, a therapist's interpretations can enter into the relationship and inform his or her actions in myriad ways, some involving a minimum of apparent intrusion: by "educating" the client; by attempting to readdress the quality and nature of the relationship; by waiting for the client to become "ready" to discuss, at a later date, the issues the therapist deems important; even by analysing (and by assuming an entitlement to analyse) to what extent, and in what ways, the client's resistance should be tackled. All of these actions are predicated on the apparent expectation that therapists should give meaning to resistance, a practice generated through the therapeutic incitement to (overt or covert; explicit or implicit; spoken or thought) discourse. The act of giving meaning to the client's refusal is an exercise of power, insofar as it moves to act both on the client's actions and on the interaction over time.

And so the meanings constructed around resistance may not be overtly "power-oriented", disrespectful, authoritative or imposing in nature, but they are effects of power insofar as they have been permitted expression through the therapeutic entitlement to understand. But these meanings can also, in turn, have effects of power: they can be used to structure the course and shape of the therapeutic relationship – in a way that would be intolerable in the other setting. They are used to inform therapist conduct, to generate or suppress topics of conversation, and to construct future interventions. In contrast, the incitement to discourse is not evident to nearly the same extent in interviewees' assessments of resistance in the business scenario. Indeed, in that setting, interviewees question the therapist's warrant or entitlement to construct meaning around the other's behaviour in the first place. "Which" discourse to use is a question that should not even be considered. It isn't her "business", and so she has no "right" to interpret it in such a way that it informs the relationship, engenders conversational topics, or unduly shapes the other's behaviour or their interaction. To do so would be discourteous, inappropriate, and disrespectful: an improper exercise of power.

What is it that makes power – through the application of knowledge - offensive in the one case, and acceptable in the other? One consideration here is that power is open to view in the business setting, but concealed in the therapeutic interaction. I have noted Foucault's (1990) view that power works to the extent that it is partly concealed. Its exposure evokes resistance, and constitutes a threat to the suggested power relation; but its concealment allows for power's relatively unchecked maintenance and reproduction. Power can be more easily contested, or resisted, when it is apparent (e.g., where the therapist is seen as acting inappropriately). It is far more difficult to counter in the therapeutic situation, however, as the therapist analyses and develops strategies

- not necessarily discussed at the time with the client (e.g., "leave it for a while"; let him "mull over it during the week") - designed to uncover or otherwise manage resistance over time. It seems that it is not power at work, but knowledge or expertise. In the process, resistance comes to mean something other than power's "omnipresent other", and its meaning is reconstructed in the terms of some therapeutically relevant discourse. In such circumstances, power is not evident or obvious in quite the same way as it was in scenario 2, but may operate more subtly, and more insidiously, fostering a gradual shaping of the relationship and of talk (and hence, of the client's talk regarding him- or herself) under the guidance of therapeutic discourse. To be clear: Power operates via discourse to shape the actions of participants, and to reinforce and extend the therapeutic discourse that helped construct the power relation in the first place – through which the therapist's discourses tend to "win out" over the client's, in sometimes ethically questionable, although often disguised, ways.

I am in no way suggesting that individual interviewees or therapists in general deliberately promote disrespectful approaches to resistance. Power has little to do with a therapist's intentions. It is discourse, especially discourse considered "true" and hence acceptable to both parties, rather than personal choice, that constructs (and is also constructed by) a power relation. The adherence to and practice of therapeutic discourse persuades therapists and clients to engage with each other "as if" just one of them knows best – even when the therapist explicitly aims to work in collaborative and democratic ways (c.f., Carpenter, 1994; Young et al, 1997).

What would a respect for resistance involve? Foucaultian scholar Christopher Falzon (1998) argues that respect involves two processes. First, it means acknowledging a person's "otherness", and recognising that subjection to any specific discourse involves a shaping and domestication of that otherness. In therapy, and in terms of our concerns in this chapter, client resistance proposes areas of otherness, outside of therapeutic discourse. Therefore an analysis of our treatment of resistance can tell us about our regard or respect for the client's otherness. I suggest that to some extent, therapy predisposes towards a neutralisation or domestication of this otherness, as therapeutic discourses shape persons so that they become recognisable and comprehensible in terms of this knowledge. That is, we proceed beyond resistance, beyond the limits proposed by the client; and we claim an entitlement to do so, based on our knowledge of what is therapeutically required.

Secondly, respect involves taking the chance that dialogue with another might lead to a transformation of our own discourses (Falzon, 1998). In relation to this point, it seems that therapy's distribution of statements functions in accordance with a belief that the human being is knowable, able to be captured within some knowledge system. Therefore, the appearance of the unknown, lying outside of our knowledge (i.e., that which is other), presents a problem for us. And yet, therapy requires a position of clienthood: one who becomes knowable. The usual result is the transformation of the client, rather than of our own discourses, into a subject upon whom our knowledge can meaningfully operate. But it is clear that a knowable client is not sufficient. As interviewers indicate, resistance against being known must be overcome in some way. The client must therefore also demonstrate a degree of malleability; to *become* willing and able -

through education, time, relationship building, mulling things over, and so on – to change in response to the therapist's interventions and knowledge. And in order to be malleable, the client must also display at least some degree of uncertainty regarding the meaning of his or her actions. (The three proposed client features of knowability, malleability and uncertainty will be discussed further in the following chapter.) The point here, in relation to Falzon's suggestion about the transformation of our own understandings and practices as a measure of our respect for the other, is that considerable changes are expected of the client in a therapeutic situation.

Certainly, we can develop new theories in response to ethical considerations and client concerns, and in that sense alter some of our discourses. But such steps typically retain the therapeutic view of clients as knowledge objects – now with even more possible ways of knowing and shaping – and consequently strengthen the institution of therapy as the prototypical place, with the appropriate kind of relationship, in which human misery can be solved. The incitement to discourse remains, although the language with which it is followed up may shift. In other words, there is the risk that the development of new forms of therapy (e.g., attempting to be more respectful of resistance) may not so much change therapy itself, but might instead contribute to the multiplication and proliferation of therapeutic discourse: a multiplication of the tools for understanding, comprehending, assessing or knowing clients. It leaves untouched the incitement to discourse in relation to which therapists and clients are positioned very differently in the first place, and which invites clients into the position of uncertain and malleable knowledge object: even before knowledge is (or is not [c.f., Anderson, 1997; Hoffman, 1992]) exercised. This discursive expansion may in turn simply reinforce therapy as institution, which in turn makes it possible to generate still more ways of capturing the other. What changes in the end is not therapeutic discourse, but the discourses of our clients.

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CHAPTER THREE
PRIMARY AND SECONDARY POSITIONS IN THE THERAPEUTIC POWER/KNOWLEDGE NETWORK[2]

3.1. Introduction

At the end of the last chapter, it was proposed that clients are positioned as knowable, malleable figures, who, in order to be receptive towards therapeutic interpretations, are implicitly expected to display some degree of uncertainty regarding the meaning of their words and actions. I also argued that new, apparently more respectful forms of therapy run the risk of merely adding new technologies in terms of which this knowability, malleability and uncertainty can be played out. In this chapter, I explore the therapeutic work associated with developments in dialogical self theory (e.g., Hermans, 2003; Hermans & Dimaggio, 2004), which is one such new approach, with these concerns in mind. Further analysis of dialogical principles in therapeutic work will be undertaken in chapter 6, where the possibility of power-free therapeutic dialogue is considered. For the moment, however, focus falls on the relationship between what can be referred to as the "primary positions" (of therapist and client) on the one hand, which seem to structure and hold in place the above mentioned client characteristics, and what will be referred to as "secondary positions," on the other: those more dynamic and fluid positions made available to participants in and through their actual talk. Following Herman's work on dialogue, this chapter examines secondary positions through the concept of "dialogical self-positions" that are evident in talk, and poses the question: To what extent do the primary and institutionalised therapeutic positions structure and condition the secondary positioning possibilities for, or the dialogical self-positions made available to, therapeutic participants? Specifically, does the particular position of client limit the sorts of "selves" that that person is able to produce and enact in the therapeutic setting?

There has been, in some quarters of the psychotherapy landscape, a problematic linkage of monologue with power, and of dialogue with an absence of power (e.g., Anderson, 1997; Anderson & Goolishian, 1987). This differentiation idealises therapeutic dialogue as an egalitarian, power-free interaction, and obscures our vision of how power works in therapy. In order to avoid such idealism, therapeutic applications of dialogical principles also need to integrate power into their formulations, rather than claim to have overcome it. Specifically, dialogical approaches to therapy need to consider power's effects on at least two levels: (1) power's role in the arrangement of the client's dialogical self positions; and (2) power's role in therapist-client dialogue. Power may be defined here as the sum total of forces that lend shape to persons' talk and actions (c.f., Foucault, 1982). So defined, power is unavoidable in the social - and hence, the therapeutic - domain. It therefore becomes meaningless to distinguish monologue from dialogue on the basis of the presence or absence of power. Rather, I suggest that monologue and dialogue, in either the internal (i.e., dialogical self) or external

[2] Chapter based on: Guilfoyle, M. (2006). Using power to question the dialogical self and its therapeutic application. *Counselling Psychology Quarterly, 19 (1),* 89-104.

(e.g., between therapist and client) domains, represent two different *kinds* of power relations. Specifically, in a monologue the question of "who influences whom?" (or, at the level of the dialogical self: "Which self position influences which other self position?") has a fixed and unchanging answer. It refers to domination, and unidirectional influence and shaping. On the other hand, a dialogue can be understood as an interaction of voices in which the issue of "who influences whom?" is never totally finalized: dialogical engagement means mutual influence. Thus, power is not overcome in dialogue, but continues to operate in un-fixed, flexible and more "turn-taking" ways (c.f. Falzon, 1998).

In this chapter, I use this dialogue-monologue distinction to centre on the tensions between dialogical views of the person on the one hand and interpersonal therapeutic dialogue on the other. Does the therapeutic application of dialogical self theory occur in a relationship that is itself a co-constructed "dialogical space" (Hermans, 2003, p. 113) or is there a fixing of the relationship that counters our dialogic intentions? What are the implications for secondary positioning options for the client? In order to address these questions, I will elaborate on Hermans' (2004) distinction between (a) power that is "intrinsic to turn-taking processes" in speech, and (b) the "institutional and societal factors that contribute to power differences in dialogue" (p. 16) (see also Hermans, 2001a; Hermans & Kempen, 1993). We must not only examine power from within the text (e.g., examining therapist-client interactions), but also as something that moves into the text from beyond it. The text (i.e., what we observe) can tell us what is being said, but as noted in chapter 1, it tells us little about the institutionalised positions from which speakers talk in the first place. Only traces of these latter positions are evident in actual speech. If we do not specifically look for these traces by considering extra-textual factors (i.e., the societal and institutional forces that Hermans refers to), they are likely to operate as invisible forces that nevertheless continue to shape the interaction and its products in the dialogical self of the client.

In particular, I suggest that therapist and client are institutionalised, primary positions that orient therapeutic participants (and observers, as noted in the findings of chapter 2) to the actions and speech of each party. To some extent, these positions predetermine and fix the shape of the therapeutic relationship. While there is obviously room for relational differences (e.g., between different approaches), all therapies contain these relatively fixed positional elements. Their fixedness is posed here as a dialogical problem, to the extent that it threatens to limit the degree to which therapy can become a true "dialogue of forces" (Falzon, 1998, p. 43).

I begin by outlining dominant cultural constructions of the therapist-client relationship, and the primary positions they make available for participants, before discussing the difficulties in escaping from these seemingly fixed positions. I will then discuss implications of these primary positions for therapeutic applications of the dialogical self, and for the production of secondary positions.

3.2. "Everybody knows" about therapists and clients

The empirical nature of the therapist-client interaction is powerfully modelled after, and also reproduces, culturally dominant ideas about what therapy is. The

broader cultural network, drawing from its long and intimate historical association with therapeutic languages and practices (Parker, 1998; Rose, 1998), has helped create for therapeutic participants a stable, capturing and to some extent prescriptive relational "therapeutic apparatus" (see chapter 8). This apparatus is propped up by the complementary, primary positions of therapist and client, which are universal therapeutic requirements.

The primary positions are separate and distinct, and those who occupy them are pressured – by "common-sense" expectations of the therapeutic process, by institutional forces such as mental health teams, but also by each other - to behave in ways that conform to these positions. In the process, power is distributed in a particular way, insuring that the person positioned as therapist has access to a form of power that is both quantitatively and qualitatively different from the power to which the client has access. The therapeutic relational apparatus makes available to the therapist (1) *more* of an influence on proceedings than client, and (2) a systematically different *sort* of influence on proceedings. However, the therapist does not control this apparatus, and cannot bend it to his or her will (c.f., Hook, 2004). Rather, she or he is positioned within it, and is likely to encounter obstacles should she or he attempt to play out anything but an expert, knowing, and talk-shaping role (c.f., Carpenter, 1994; Young, Saunders & Prentice et al, 1997).

In order to clarify the functioning of this therapeutic apparatus, let us begin by considering the following interaction between a therapist and a client:

Extract 1[3]

Susan: My dysthymia is back!
Chris: Oh, what makes you say that?
Susan: The other day… (relates an incident where she became anxious about meeting her boss)… and I know anxiety is a sign of dysthymia.
(6 minutes later)
Chris: I'm just wondering, how do you decide between anxiety that we all have from time to time, and anxiety that is a sign of dysthymia?
Susan: Um (3 second pause) I don't know I s'pose (laughs).
Chris: Cos I was wondering that if I get nervous about meeting <u>my</u> boss, how do we know if I am dysthymic or not?
Susan: (6 second pause) I don't know. You know also, I think that when I said earlier I was annoyed because it was dysthymia coming back, could it be I was just annoyed, in a normal way?
Chris: Well it could be. I'd be afraid to think that just because I was annoyed or anxious, that that meant I was dysthymic! It's only a thought, I'm not sure, what do you think?

Note that I have not specified who the therapist is or who the client is. Nevertheless, we can be confident that most readers would guess that Chris is the therapist and Susan is the client. There is something about this interaction that

[3] This extract derives from a session hosted by myself, and the client consented to its use in this text. Both names have been changed to protect the client's confidentiality, but also to facilitate indeterminacy regarding each person's primary position, which, as shall become apparent, is essential to the writing up of this chapter.

tells professionals and common-sense knowers alike that it makes sense to attribute positions to participants in this way, but *not* the other way round (i.e., with Susan as therapist and Chris as client). There is a set of culturally available and widespread knowledges about what a therapist is, what a client is, and what their interaction should look like: these give us important clues about how to read extract 1. These knowledges tend to be background rather than foreground knowledges, and are typically introduced into therapeutic interactions without being noticed. It seems that the therapist, on the one side, and the client, on the other, are just *there*. Very little therapeutic work needs to be done on the question of "who will count as whom in this interaction?" Certainly, some modifications may occur as therapists use approaches with specific relational requirements, but clients are able – by virtue of their "enculturation" (Swidler, 2001) as common sense knowers – to orient more or less appropriately to the client position, which makes the realisation of specific relational requirements an achievable task. Therapeutic participants simply immediately, automatically and imperceptibly move into their (more or less) appropriate positions – which are relational, mutually referential and complementary in nature – as soon as they meet. "Everybody knows" who is the therapist and who is the client in extract 1.

But what is it that everybody knows, that allows such (apparently) accurate recognition?

3.3. The cultural construction and positioning of therapists and clients

I propose that therapists and clients are widely regarded in the following ways. As suggested in chapter 2, the client is that person who becomes, by virtue of the assumption of a client position, (1) knowable, (2) malleable, and (3) deferring. I will outline each of these points in turn. First, the client is deemed knowable in that she, and her problems, can be captured by therapeutic knowledge systems. For example, in terms of the theory of the dialogical self, she may be constructed in terms of dialogical self-positions that make sense of her presentation. Practitioners of dialogical therapy can – at least in part – "know" or understand that person's experiences and behaviour because of a theoretical system that gives therapists implicit and explicit rules for identifying and engaging with the repertoire of that person's self-positions. Thus, we might note that Susan initially displays an "I-as-dysthymic" self-position, and that other voices support that position (e.g., annoyance and anxiety). We create a "way of knowing" about Susan, having already assumed in principle (before meeting her) that her actions and experiences can be captured in this way.

Second, the client is deemed malleable because she or he comes into therapy hoping for change, ideally with a readiness to change, and because therapy involves the generation of new ways of thinking or talking or doing. A client must be ready – or through the resolution of resistance, become ready - to shift in all manner of ways. For example, because she is a client, and if therapy is to be successful, Susan must recognise that the dysthymic self-position as she presently constructs it is but one of many possible positions.

And third, deferral indicates that when persons become clients, their interpretations of events are often held in parentheses. Deferral here does not mean that clients defer to the apparent wisdom of the therapist. Rather, it

prioritises the idea that clients' accounts are not yet final; their meanings are "yet-to-be-decided". This is a deferral of meaning. The meaning of clients' experiences must be deferred if therapy is to function adequately. With respect to extract 1, the initial certainty of Susan's dysthymic self-position might constitute an impediment to therapeutic change, to the extent that she perhaps believes that she is "failing" (because her "dysthymia is back"), or that she is powerless in the face of the dysthymia "illness". She must therefore be ready to un-finalise what seems to be her final meaning, to avoid becoming trapped in a narrowed self-system dominated by the dysthymic position. Any absolute fixity of meaning precludes therapeutic action, and so if such deferral is not evident, the therapist has to take steps to remedy this situation.

To be clear, this does not mean that clients necessarily actually display these qualities (c.f., Semerari et al., 2004). The opposition to therapeutic power operations (i.e., resistance) on many levels is always possible. However, these features are offered here as requirements for a specifically therapeutic sort of *change*. After all:

> For therapy to be successful, patients have to actively want this. If they are to change their point of view about the world, they need to start a dialogue with their therapist, listen to the latter's interpretations and suggestions and try to look at themselves from this new perspective (Semerari et al., 2004, p. 220).

While Semerari and colleagues' somewhat directive take on therapeutic action might invite objection from avowedly collaborative therapists, their characterisation of the therapist as (directly or indirectly) producing "new perspectives" appears to be borne out in several studies of collaborative approaches (e.g., Kogan, 1998; See also chapters 5 and 6). If therapy is to be successful, clients should be knowable, malleable and deferring. But it is notable that clients do not have to be told about such requirements. Typically, they are already informed by and pressured from all manner of sources to adopt such a position relative to the therapist: it is part of what "everybody knows."
On the other hand, the therapist is that person who becomes, through the assumption of the therapist position, an expert knower. Therapists are the officials, the culturally designated "truth-tellers" on psychological and therapy related matters (Rose, 1998; see also Hook, 2004). This position allows them – or lends them an entitlement, as discussed in the previous chapter - with the support of the culture and dominant institutions, to shape the client's words so that the client eventually conforms to, and can be captured in the terms of, a particular therapeutic knowledge system. Change, or problem understanding and resolution, may occur in the process.

These primary positions of therapist and client lend a shape to, and coordinate, both persons' participation in the therapeutic interaction. Thus, the therapist's expertise and talk-shaping activities may easily be considered out of place in other (non-therapeutic) social settings. The enactment of therapeutic expert knowing is relationally conditional: it is legitimate in some settings but not in others (as argued in chapter 2). This applies equally to the client: his or her knowability, malleability and deferral may well be features of his or her adoption

of a client position, but they may not be evident or appropriate in other areas of his or her life. Therapy may thus involve much rhetorical work – for instance, in the face of resistance - to encourage him or her to demonstrate the appropriate client features. Like any other institutional practice in which primary positions are prescribed, therapy requires that persons present themselves in particular ways: only specific "sorts" of persons make therapeutic practice possible. Thus, with reference to extract 1, it would be misleading to characterise this interaction as occurring between an unhappy person and a supportive person. Because these persons are in therapy, they are transformed into, respectively, an unhappy *client* (i.e., knowable, malleable and deferring) and a supportive *therapist* (i.e., an expert knower). Both participants have to assume the appropriate personal configuration of self-positions to make therapy possible. For the therapist, such qualities as knowing and expertise (and acceptance, composure, listening, analytic abilities, etc) are brought to the fore. On the other hand, the client is encouraged to bring to the foreground a flexible self-questioning and a willingness to become known.

We should therefore not assume that therapy calls the client to present in a manner that is congruent with some "true" self. Rather, in order to be a client, that person needs to adopt a specific meta- (or primary) position, characterised by knowability, malleability and deference; to make him- or herself open to discursive capture, re-interpretation and reconstruction. Thus, it may be misleading to characterise therapy as "two persons talking"; rather, it may be more accurately understood as a conversation between, precisely, a person positioned as a therapist and another person positioned as a client.

As is evident from the preceding discussions, many therapists may object to such formalised positioning, and strive for a more egalitarian arrangement. This is clearly the case in most therapeutic applications of the dialogical self (e.g., Hermans, 2001b, 2003; Hermans & Hermans-Jansen, 2004). But there are at least two sorts of difficulties to be faced here. One relates to our preconceptions of persons positioned as clients; the second difficulty is a question of our capacity to achieve such democratisation. Let us consider each in turn.

First, in aiming at collaboration, the dialogical-self therapist creates a specific position for the client to occupy: collaborator or co-investigator (Hermans & Hermans-Jansen, 2004). This is the kind of relationship dialogical-self therapists want with their clients. At first glance, this positioning seems to contradict the three features of clienthood suggested above. But, paradoxically, the *a priori* (i.e., before therapy even begins) positioning of the client as a collaborator already presupposes – it is an anticipation of - that person's knowability, malleability and deference. It entails an assumption that this person will be able to arrange his or her self-positional configuration so as to permit the adoption of this meta-position (as opposed to adopting the interpersonal positions of, for instance, subordinate, pupil or "patient"). To be a "collaborator" requires an appropriately corresponding internal arrangement of personal positions. It is not a neutral position, and as we shall see below, it may even be considered an unusual or unexpected position in this situation.

Merely in proposing this or that way of conducting therapy, therapists assume that clients are malleable and deferring enough to "fit" into the primary positions created for them, and that clients can become known in the way

therapists prefer. The client is thus already incorporated into one or other discursive framework, and his or her words become examples of the therapeutic discourse that claims it. The simple practice of "having" or using a theoretical framework in the first place indicates that therapists consider this to be a legitimate *pre-therapeutic* activity. This is already a declaration of power, in that it declares the therapist's capacities to shape the client's position and the meaning of his or her narrative accordingly. And this is accomplished before even meeting with that person.

This pre-therapeutic construction of the client is undermined by a second difficulty. The ideal of therapeutic equality, however it is conceived, runs counter to the widespread cultural expectations of that relationship. From the perspective of the dialogical self, this means that the client's representation of the therapist may differ significantly from how the therapist would like to be seen. The alteration of this perception appears, despite therapists' efforts, to be difficult to achieve. Indeed, clients who attend collaboratively oriented therapists often continue to see their therapists as "expert knowers" during and after therapy (Young et al, 1997). In some cases, therapists who do not conform with sociocultural expectations of what a therapist should be like (such as using diagnostic labels or offering expert interpretations), may be seen as disingenuous (Golann, 1988) or even as "strange" or "eccentric" (Shawver, 2001).

The client has good reason to expect expertise: this is the culturally dominant view of what we do, and these dominant discourses circulate in the words and actions of referrers, family members, the media, and other mental health professionals who might be involved. Claims to the contrary appear to fly in the face of common sense. It is likely that all experienced collaboratively oriented therapists have faced clients who, preferring clear and knowing expert interventions, are frustrated at the therapist's attempts to alter the more well-known configuration of the therapeutic relationship. Thus, despite our attempts to position the client as a collaborator, it may transpire that the client, supported by a host of cultural discourses that affirm his or her resistances in this regard, experiences such positioning as untenable, and perhaps even as a misrepresentation of his or her life situation and of the help that is needed. There is always the risk, if the *therapist* views herself as a dialogical self, that her own internalised client positions (i.e., her constructions of the client position) may be more related to her theoretical dispositions than to the realities of the other. In other words, the therapist's images of collaboration may correspond more with that person's ideals and theoretical dispositions than with the actual empirical therapeutic encounter.

3.4. Primary therapeutic positions and the circulation of power

The dominant social constructions of what therapy is, what a therapist is, and what a client is, help to construct a particular therapeutic relational apparatus. This apparatus structures, organises and maintains the therapeutic interaction, at least partly by regulating the circulation of power; which at a local level refers to the ability of different participants to shape or fashion the interaction, and to shape the talk that ensues. Perhaps it is clear by now that these affordances of access to power, to the therapist and client respectively, are not merely produced

within the therapeutic setting itself. Rather, they are made possible and reproduced by the broader circulation of cultural knowledges (i.e., common-sense) about, and expectations of, therapy, therapists and clients. As noted at the outset of this chapter, we need to look "beyond the text" to understand how power works.

The proposed therapeutic apparatus may be depicted diagrammatically (see figure 3.1). At a broad level, therapy involves the following cycle of interaction. The client makes an utterance (a). The therapist engages in internal dialogue (b). The therapist responds to the client (c). The client engages in internal dialogue (d), before responding to the therapist (a), and so on.

But the culturally sustained therapeutic apparatus produces for the therapist's statement (c) a force that is not only more significant than that of the client (a), but which is also oriented rather differently. These differences in orientation systematically reinforce the inequality of the respective forces associated with the primary positions. I suggest that the therapist's statement is invested with a "shaping force", which is of greater magnitude than the client's statement. On the other hand, the client's statement is invested with what may be termed a "suggestive" or "implicative" force (to borrow a term from Pearce and Cronen [1980] and Tomm [1987]). I will elaborate on these forces by returning to extract 1 (on p. 101 above). Let us imagine, as our socially constructed common sense tells us, that Chris is the therapist, and Susan is the client.

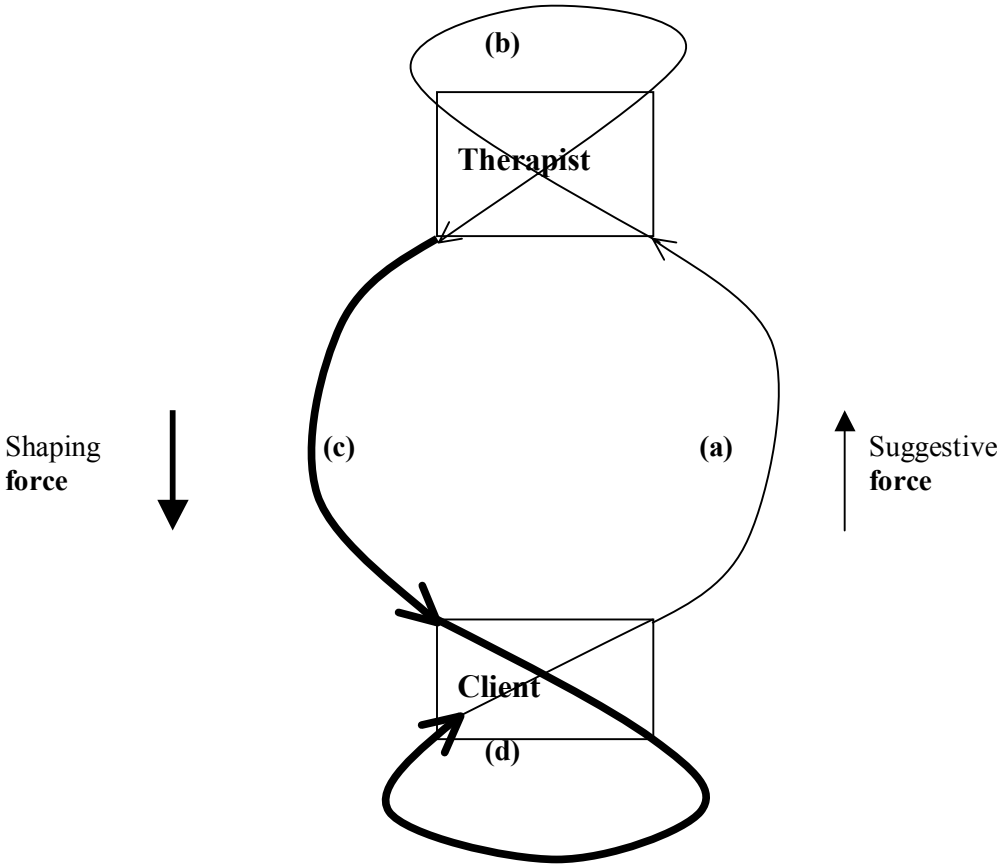

Figure 3.1: The circulation of power in the therapeutic relationship

In accordance with the proposed therapeutic apparatus, Susan's words are seen here as being made available to the therapist for reconstruction. They are merely suggestive to the extent that no final meanings are contained within them, and they have a "not-yet-decided-upon" quality. The client does not yet know what they will become examples of, or how they will be categorised. Certainly, Susan is clear on what she is saying. But the fact that she is positioned as a client in conversation with a therapist suggests that the meaning of what she says is yet to be decided. Initially, she constructs certain events in her life – where she has been anxious and annoyed - as examples of "dysthymia's return." She adopts a position of "I-as-dysthymic". But within a short space of time, her certainty is eroded, and a new I-position emerges, that absorbs and gives altered meaning to her anxiety and annoyance: perhaps these experiences are "normal". Her words and the meanings associated with them have an as-yet-undecided quality, even when she appears certain about what she thinks. In other words, there is something of a superordinate "I-as-client" position – relative to the other as therapist - that introduces a degree of uncertainty regarding her self-positions.

It should be noted that the therapist's words in this encounter have a "not knowing" quality. They constitute attempts to continually position the client as a collaborator and a co-investigator. This is evident through the passage in the form of "discursive uncertainty markers" (see chapter 6), which are attempts to communicate that the therapist does not hold the final meaning. For instance, Chris tries to remove authority from his statements, using the following sorts of words: "I'm just wondering… I was wondering… it could be… It's only a thought, I'm not sure, what do you think?" He appears to be constructing a particular and mutual positioning relational system: therapist and client as co-collaborators. And yet despite this tentativeness, the content knowledges that are interpreted (by the client) to lie behind his words seem to have a significant shaping effect. The simple question – "how do you decide between anxiety that we all have from time to time, and anxiety as a sign of dysthymia?" – functions to powerfully undermine the client's certainty, not because of the logic implied in the question, but precisely because it comes from a therapist, who is now positioned not as a collaborator, but as an expert. In this regard, consider that in this case Susan's mother had, a few days earlier, advised that such anxiety was "normal". However, Susan believed that her mother didn't know enough about dysthymia or anxiety to make such a judgement. On the other hand, the therapist's words are the words of an "officer" of society's formalised psychological truths (c.f., Hook, 2004), and thus have greater impact.

The therapist's input can have a shaping effect, even when the person in that position attempts to speak in tentative, uncertain and not-knowing ways. Clients are influenced to "hear" expertise from the therapist, even when such certainty is not offered. Thus while the therapist may seek to favour the client as the expert on content matters, and to hold onto a more methodological or process rather than content expertise (c.f., Hermans, 2001b), this preference is undermined in practice as it appears to run counter to culturally dominant versions of the therapeutic encounter, and thus counter to common-sense. We cannot avoid suggesting content information, even if we strive not to impose in this manner.

For example, Chris' question about how one decides between normal anxiety and dysthymic anxiety does not in itself indicate that the former is the more accurate or useful characterisation of Susan's experience. The logical form of the question is no different from the question: "How do you decide whether you want to follow career path x or career path y?" Such a question suggests, in itself, no desired answer. Why is it that the therapist's question about anxiety (as dysthymia or normal) seems to be *heard as* already containing an answer? Semerari and colleagues (2004) note that the client's "metarepresentations" of what the therapist means or thinks often does not accord with the therapist's thinking or intentions. (These authors recommend self-disclosure to rectify this situation, although as shall be discussed below, such intervention tends not to alter the respective orientations of the primary positions.) And so the results or effects of the therapist's words may deviate from the therapist's intentions. Therapists' voices carry the force of the primary position that they occupy. And it may be because of this primary position that the therapist appears to suggest specific positionings for the client while undermining others (in this case, "client-as-normal" above "client-as-dysthymic"). In this way, the therapist's input lends a shape to the client's secondary self-positions, even in unintended ways.

The client's statements function as "raw materials" to be shaped up in one way or another, not necessarily by the actual empirical activities of the therapist, but certainly (if it is "good" therapy) *through* the therapeutic process. These statements are not yet decided upon, and are made available for classification or re-classification. She may feel she has discovered "the final truth" at some point, even without the therapist's help. But this decision does not make her interpretations invulnerable to ongoing therapeutic re-interpretation. The assumption of the client position means that the meaning of that person's talk is perpetually deferrable. Thus, the client's account has the force of a suggestion, an as yet unclaimed example, which is always vulnerable to re-interpretation. The therapist's questions and observations have the effect of interventions; they shape up the client's talk. His or her talk introduces – sometimes inadvertently – ways of organising and structuring the discursive raw materials offered by the client. The therapist does not have to say or even mean "those experiences are normal," for the client to "hear" this as an emerging meaning.

3.5. The primary positions and their resistance to change

It seems that this therapeutic apparatus may also resist alteration. There is significant cultural, institutional, professional and even personal pressure exerted on therapeutic participants to adhere to their primary positions. Nevertheless, deviations are sometimes evident. In such instances, it is hypothesised that a range of pressures will be exerted on both parties to return to their respective positions: towards the unequal but complementary starting point from which interpersonal therapeutic dialogue typically ensues. Therefore, it may be that whatever happens, therapeutic processes tend to gravitate, or be "pulled," towards the culturally constructed therapeutic apparatus, and its participants towards their complementary primary positions.

I will illustrate this by reversing the primary positions we decided upon for extract 1. Let us imagine that we were mistaken in our original attributions:

Susan is actually the therapist and *Chris* is actually the client. This situation is depicted in extract 2 below (in which I refer to participants by role rather than name, to facilitate clarity). If the relational apparatus pulls participants towards their primary positions, then we must ask how the client's *therapist-like* behaviour is suggestive rather than shaping, and how the therapist's *client-like* behaviour is shaping rather than suggestive. Let us consider the following altered interaction with this question in mind.

Extract 2

Therapist: My dysthymia is back!
Client: Oh, what makes you say that?
Therapist: The other day… (relates an incident where she became anxious about meeting her boss)… and I know anxiety is a sign of dysthymia.
(6 minutes later)
Client: I'm just wondering, how do you decide between anxiety that we all have from time to time, and anxiety that is a sign of dysthymia?
Therapist: Um (3 second pause) I don't know I s'pose (laughs).
Client: Cos I was wondering that if I get nervous about meeting my boss, how do we know if I am dysthymic or not?
Therapist: (6 second pause) I don't know. You know also, I think that when I said earlier I was annoyed because it was dysthymia coming back, could it be I was just annoyed, in a normal way?
Client: Well it could be. I'd be afraid to think that just because I was annoyed or anxious, that that meant I was dysthymic! It's only a thought, I'm not sure, what do you think?

The oddness of this interaction clearly lies in the reversal of what most of us consider the appropriate positions for therapist and client. Despite identical dialogue to extract 1, its meaning now changes altogether. Most common sense knowers might see the therapist's client-like actions as inappropriate in extract 2 (when she *is* the therapist), but as appropriate if she *were* the client (as in extract 1). On the other hand, the client's therapist-like actions of extract 2 seem out of place, because he is not the therapist. The obvious point to be made here is that the meaning of what a person says changes depending on the primary position she or he occupies.

But I suggest that the therapeutic relational apparatus will tend to resist this sort of interaction. Ample opportunities are made available to participants to reinterpret that interchange so that the apparatus itself – and the integrity of its primary positions - remains intact. In other words, it becomes possible to characterise the therapist's client-like input (of extract 2) as comprising a shaping force, and the client's therapist-like input as a suggestive force. But how could such an argument be made? I suggest that almost any activity of the therapist could be interpreted to carry the heavier weight of a shaping force; and that almost any activity of the client could be made to carry the lighter weight of a suggestive force. And so a series of pressures might be exerted on therapist and client in extract 2 to interpret their seemingly odd interaction in terms of its culturally constructed and accepted form. For example, the therapist (Susan) could say to her supervisor, or to the mental health team to whom she is

accountable, that she is modelling transparency for the client. Or the client's (Chris') therapist-like behaviour might come to count as "practising his listening skills," when his spouse has complained that he does not listen. Or the interaction might be justified by claims that the client feels increasingly empowered by his supportive role in relation to the therapist, in the context of previously feeling intimidated by authority figures.

A good example of such an apparent reversal of roles is reported by Semerari and colleagues (2004, pp. 226-227). In that case, the therapist tells a socially anxious client about his own experiences of embarrassment in interpersonal situations where he feels he does not belong. According to these authors, this disclosure is designed to facilitate the client's interior dialogue with the therapist position (i.e., to help the client to internalise and internally engage with a more realistic and accessible therapist image). Thus, the therapist's self-disclosure is invested with properties – not to be found in the words themselves – that mark it as a different sort of communication than the disclosures of the client. His self-references do not become discursive raw materials offered up for clarification and shaping by therapeutic operations. Their meanings are not uncertain (as they would be for the client), and they are not parenthesised, because he is not positioned as a knowable, malleable and deferring person in this interaction. Rather, his words have, precisely, a shaping effect. Therapist self-disclosures become interventions. In this instance, they make available to the client an alternate dialogical self position modelled on the therapist; one who acknowledges and normalises anxiety in unfamiliar interpersonal situations. In other words, the therapist's client-like words lend shape to the dialogical interactions between the client's *secondary* self-positions.

On the other hand, continuing with the work of Semerari and colleagues, the client's responses to therapist disclosures easily (though not necessarily) retain their uncertain status. For instance, we might wish to see whether or not the client "gets the message" we are trying to impart. And in this particular case she does, confirming in her speech a growing ability to engage with the therapist position to make her experiences of anxiety "intelligible and controllable" (Semerari, et al, 2004, p. 227). The therapist's self-disclosure has the desired shaping effect. And the client's responses become implicative in that they do not so much inform the therapist of how to deal with his own anxieties, but instead indicate to the therapist something about her internal arrangement of dialogical self-positions. Her words become examples of the therapist's theoretical system.

The unusual interaction of extract 2 could become, with very little effort, an example of the very apparatus it seems to undermine. The client's therapist-like actions may be converted into raw materials to be known, or shaped, in one or other way (e.g., as "listening," "empowerment," or as indicating where his internalised therapist position needs to be altered, etc.). Equally, the therapist's client-like actions may be converted into relationship-shaping and therapeutic actions (e.g., by altering the client's arrangements of self-positions).

3.6. Implications for therapeutic applications of the dialogical self

I am not advocating a rigidification of the therapist and client positions; and I am not trying to de-humanise therapeutic practices. And yet there may be something

about the structure of the therapeutic situation that pushes our practices in these directions: towards a fixing of the relationship so that I-Thou interpersonal interactions become severely circumscribed. There is something about being a client in therapy that not only positions that person as amenable to change, but also as vulnerable to being shaped in accordance with the therapist's intended (i.e., what is sometimes termed "directive") or unintended (i.e., what is sometimes termed "non-directive") exercise of power. The primary client position is an often invisible but superordinate position – a metaposition – that regulates that person's interactions with the therapist so that therapeutic shaping power can be optimised. It thereby gives the secondary self-positions that emerge in therapy talk a degree of uncertainty, and a deferring quality, which in turn makes them susceptible to alteration. On the other hand, there is something about adopting the primary position of therapist that powerfully, though also often invisibly, persuades us that we can know the other, and that legitimises our tendency to lend a shape to the other in ways that conform to our preconceived theoretical notions. We easily assume as unproblematic our pre-therapeutic and within-therapeutic positioning of the client as a knowable, malleable and deferring other.

The problem, however, is that in doing so we too easily imagine our work, at the empirical interpersonal level, as a person-to-person phenomenon, as one "I" relating to another "full-fledged 'I'" (Bakhtin, cited in Hermans & Hermans-Jansen, 2004, p. 20). I suspect this to be an idealisation that may well be unsustainable. It obscures – and to some extent may also rely upon the obfuscation of - the therapeutically pervasive problem of power. Ultimately, it seems that what power aims at in therapy is an overcoming of the other. I will spell out what I mean by this.

First, the client's otherness is already made familiar in his or her adoption of the client position, with all of its implicit – but well known to all – rules for action and interaction. The other becomes, at least to some extent, a known or a discursively captured other by virtue of the "knowledges" we use to position him or her even before therapy begins. Thus, with reference to extract 1, the client has already been recognised as a dialogical self before therapy begins, and so we can predict well in advance that some of her self-positions, and something of their arrangements, will be demonstrated in her talk and actions. We also assume that to some extent at least, she may go along with – or through an overcoming of resistance, be persuaded to go along with - our theoretical applications. And because we have access to an increasing literature on the dialogical self in therapy, we also can be ready to deal with and overcome problems that might emerge in applying our concepts. Thus, while we do not yet know (before therapy begins) exactly which positions will be demonstrated, her positioning as a client grants the therapist a cultural and professional entitlement to apply (for example) the dialogical self knowledge system in relation to her conduct. We know, in advance, that we have a system to enable the recognition and discursive capturing of her otherness.

Second, and considering then what occurs once therapy has commenced; as we decide - in a way we hope is collaborative – that the client operates in this or that self-position, his or her otherness is further tamed, and she or he becomes a more refined example of the discourse *we* speak. The client of extract 1 (Susan)

is now not just a dialogical self in principle, or in the abstract, but as she speaks we can increasingly pinpoint her self-positions: as dysthymic, normal, anxious, annoyed, etc. We can also work out schemas to understand their organisation. For instance, the dysthymic position seems "meta" to the anxious and annoyed positions, in the sense that these latter problems have been constructed (by her) as examples of dysthymia. At this point she is not just a crudely known malleable and deferring other (i.e., any client), but someone whose unique experiences can be more neatly classified in terms of the self-positions they embody. (I shall address the claim of collaboration in this respect below). Susan becomes a "filled out" and nuanced case, an example, of the preferred dialogical self-theory, in terms of which her presentation has been given a shape. Our theories are confirmed, and the client is in agreement.

This is not a discovery of the other; it is a conditional knowing and a disciplining of that person, in which she or he is persuaded to know him or herself in a way that we therapists find familiar. Over time, as therapy progresses and the client begins to apply the notions of the dialogical self to his or her situation (e.g., through the Self-Confrontation Method or the Personal Positions Repertoire; Hermans, 2001b), this other being begins to recognise him or herself in the specific therapeutic discourses that are deployed (see also chapter 5 for more discussion on this process of subjectification). He or she is shaped into a now mutually recognisable dialogical self, whose utterances and experiences become merely examples, or implications, of this particular version of self.

This could not be recognised without an appreciation of power and of its tendency to invisibility; of the unseen shaping effects of the primary positions on therapeutic happenings. It is with these concerns in mind that the concept of power is recommended for more systematic attention in therapeutic applications of the dialogical self. As noted at the outset, it is true that power's effect on dialogue has been theorised to some extent (e.g., Hermans, 2001a, 2004). However, I argue that the institutional and societal forces that Hermans highlights are far more significant than we might have expected. In particular, they are not resolved by referring to our work as collaborations or co-investigations.

The inadequacy of this solution (i.e., naming therapeutic work "collaborative") lies in its pretensions to have solved the problem of power. But a collaboration of more or less equal partners does not begin and end with a therapist's attitudes or actions. Even if therapist and client agree to "collaborate" – an increasingly popular phrase in a range of therapeutic approaches (Goldberg, 2001) - we must consider the effects of the societal and professional network that demands expertise on the one hand, and knowability, malleability and deference on the other. Significant external and internal forces will likely combine to revert persons to their socially constructed primary positions. Collaboration is a relational configuration that may in some ways be structured *out* of therapeutic practice before it even begins. Or rather, we might say that the therapeutic relational apparatus limits what collaboration can mean in that context. This does not necessarily preclude the experiencing of I-Thou moments, but we face the significant task of trying to figure out how we might attain those moments without losing our respective primary positionings; and without losing sight of therapeutic goals. We must begin then, not with an examination of the self-positions that emerge within therapy talk, or of how we might facilitate their alteration, but with

an analysis of the shaping effects of the therapist and client positions on the interaction between these two individuals, dialogical selves though they may also be. By understanding these, we might gain a better appreciation of the forces involved in the generation of new or altered self-positions, and consider more carefully whether in the process we overcome the other who becomes the client, by turning him or her into merely an example of our theories.

To be clear, this is not a challenge against the concept of the dialogical self per se. This view of self allows us to see ourselves and others as fundamentally interconnected, each of us an unfixed, and hence dialogical, internal "society" of positions (Hermans, 2001a, 2003); it is a view that moves us *away* from psychology's historical tendency towards the objectification and individualisation of persons. My questions really are directed at *therapeutic applications* of the concept. There is something about therapy's institutionalisation that threatens to capture this theory of self, and to subvert it to its own ends. Under the umbrella of therapeutic practice, the dialogical self risks becoming merely yet another set of ideas and techniques for capturing and transforming the other, through his or her construction as a knowledge object. That this may benefit the client is not in doubt, but in the presence of a vast number of "effective" therapeutic practices (at least from the perspective of "symptom reduction"), the question arises of whether we need yet another concept – the dialogical self – to promote therapeutic change. So we must clarify: What can this concept add to the field of psychotherapy without itself being tamed or domesticated? The strength of the concept of the dialogical self lies in its vision of change, fluidity, un-fixedness, and "un-finalizability" (c.f., Bakhtin, 1981): this is a self that defies objectification. Correspondingly, the singular strength of the concept of dialogue itself lies in its ability to facilitate an appreciation of the other *as other* (Falzon, 1998). It is by no means clear, and nor should it simply be accepted without question, that the therapeutic relationship is capable of realising these visions.

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CHAPTER FOUR
RHETORIC AS A VEHICLE FOR THERAPEUTIC POWER/KNOWLEDGE[4]

4.1. Introduction

In chapter 2, I argued for a view of therapy as a power/knowledge network, in which the requirement that a client's experience becomes subject to interpretation involves an "incitement to discourse". The very process of making meaning out of the client's behaviour and experience – constructing him or her as an object of knowledge - predisposes to the reproduction of a power relationship in which apparently disrespectful, ethically questionable therapist conduct can, through the invocation of knowledge, be legitimised and then disguised as respectful, appropriate and ethically acceptable practice.

In this chapter, I consider how the power/knowledge network relates to actual talk in therapy sessions. As was mentioned in chapter 1, in therapy practice, talk is considered an application of power, one of its "ultimate destinations". On this account, power becomes entwined with discourse to be channeled into and practiced through the conversations that occur between therapist and client. It is for this reason that studies of the rhetorical processes that occur in that interaction are important. Rhetorical analyses point to the strategic interpersonal relations, or processes of argumentation (Billig, 1990; 1996), through which power and its other – resistance - can be played out. This study will investigate the possibility of considering therapeutic talk as consisting in a relationship of persuasion (c.f. Frank & Frank, 1991): persuasion here being considered a local tool for the operation and realization of power.

However, an analysis of power must go beyond the simple assertion that there is a power relation, indeed, an inequality of access to power, within therapy. While I made this point with reference to knowledge and resistance in chapter 2, and showed how seemingly disrespectful practices get discursively "cleaned up," concealed and put into operation, the issue of power leads us to raise a more fundamental question: Does this power relation within therapy map in any way onto power relations in society in general? Does the inequality of the therapeutic relationship discussed in chapters 2 and 3 collude with broader power processes, serving as a tool of "social control more than social change" (Hare-Mustin, 1993, p. 20)? As Goldner (1993) asserts, "psychotherapists cannot help beaming their version of 'truth' to their clients, no matter how committed they are to a stance of neutrality" (p. 160). Certainly, the specificity of this "truth" will vary from therapist to therapist, depending at least in part on their theoretical orientation: for example, psychoanalytic "truths" about resistance (e.g., as part of a transference reaction) are very different from cognitive "truths" (e.g., as behavioural noncompliance). But there may be a level at which these disparate and discrete knowledges converge, and it is at this level, which may be concealed by the attention to conceptual differences, that it becomes possible to ask about therapy's relationship (i.e., incorporating most approaches) to the broader culture.

[4] Chapter based on: Guilfoyle, M. (2002). Rhetorical processes in therapy: The bias for self-containment. *Journal of Family Therapy*, 24 (3), 298-316.

The question to be posed in this chapter is whether we can discern, in therapeutic rhetoric, the force of a discourse whose function is to install and reproduce a certain, and culturally specific, way of being a person. Do therapeutic practices facilitate a particular version of personhood? It will be argued that therapy practices tend to favour accounts of the person (i.e., the client) as "self-contained" (Sampson, 1993). In this chapter an analysis of a family therapy case will demonstrate a discursive allegiance to key features of self-containment, thereby favouring a western construction of persons. This allegiance is considered to take a rhetorical form: (1) rhetorical devices in talk between therapist and family members function to construct narratives of self-containment; and (2) alternative narratives are implicitly and explicitly criticized. The therapist's activity in promoting and managing this talk will be highlighted as an operation of power, which perpetuates not just therapeutic discourse, but the prevailing – and sometimes binding - western discourse of the human being. In this way, it is not just a local power relation that is produced and reproduced, but also the predominant power relationships and shaping procedures that occur in our discursive and institutional cultural context.

4.2. Conceptual Issues

4.2.1. The self-contained individual

Contemporary western persons typically see themselves as individuals, "self-determining authors … in charge of their own life's work" (Sampson, 1989, p. 915), expected to take responsibility, earning credit or blame, for their actions. It has been suggested that this individualized view of self is based on western values (e.g., Geertz, 1979; Rose, 1998; Sampson, 1993), and finds expression in many forms of therapy (Gergen, 1999; Pilgrim, 1997). In addition to an apparent cultural bias, individualized constructions of the person are also seen as ethically and epistemologically problematic (e.g., Bateson, 1972; Holdstock, 2000), leading many therapists towards a more relational than individualized construction of persons (e.g., Hermans & Hermans-Jansen, 2004; Hoffman, 1985; Roberts, 1998; Tomm, 1987). Nevertheless, given that therapeutic theory frequently differs from practice (Golann, 1988), and the tendency of western institutions to favour individualized accounts of people (Rose, 1998), there may be difficulties in avoiding individualizing tactics in therapy practice. In order to explore this possibility, it is first necessary to explicate the meaning of self-containment.

Sampson (1989, 1993) describes the self-contained individual as the embodiment of two principal features. First, the individual has ownership of itself, its characteristics, attitudes and achievements. It is self-determining. Second, boundaries between self and other are required for autonomous functioning, which is seen as vital to psychological health or maturity (Alladin, 1999). The idea of self-containment does not deny the importance of relationships with others, but disavows the constitutive role of interactive processes. In this sense, it differs from the "relational self" (Gergen, 1999), which posits the self as constructed in and by relationships.

Here we find an apparent paradox: the self-contained individual is dialogically constructed (Sampson, 1993). Any characterizations of the self (e.g.,

as independent, agentive, or self-determining) are only made possible via relationship processes (Gergen, 1999). Thus, self-containment can neither be created nor maintained without the involvement of others in its construction and reproduction. Sampson highlights oppressive ways in which one group may define itself in desired and self-contained terms by attributing less desired qualities to "serviceable others", using them as "hidden dialogic partners" (1993, p. 19). Thus the devaluation of others (e.g., dismissing them as "emotional") allows for the development and maintenance of a preferred view of self (e.g., as "rational"). However, the relational or dialogical means by which this view is constructed (the oppressive construction and devaluation of the other) is denied, or hidden. Such denial makes it possible to see rationality (or any other desired quality) as self-determined, built up by and within the self (i.e., a monological account), rather than as merely a construction enabled by the definition and devaluation of the other (i.e., a dialogical account). In this sense, there is a partnership between self and other, in which the latter is defined negatively, and then used as a contrast against which the self's apparently positive attributes can be made visible. If, however, we expose the various ways in which these partnerships are used to construct preferred views of the self, self-containment, according to Sampson, is revealed as illusory: allowed to appear only by denying the role of the other, which thereby conceals its apparently fictional status.

Two important points must be made about this dialogic account. First, in constructing the self in one way and others in another, discourses become invoked or constructed that not only position people (self and other) in different ways, but that function to construct social reality in terms of the very categories constructed (Foucault, 1972). Thus, attributions made can become part of the fabric of people's social existence, and should not be considered "false" or "merely constructions" (as will be illustrated in the case below). Secondly, we must attend to the broader way in which *both* parties (the "oppressors" and the "oppressed"; the desirable and the devalued) are subject to the discourses and practices of self-containment. We should avoid a picture of perpetrators and victims, but highlight instead the processes that enable such differential constructions to take place in the first place: the discursive establishment of the "persons-as-individuals" discourse (i.e., self-containment) *as truth*. This distinction is crucial, for it allows us firstly to move away from the notion that some (i.e., the "powerful") construct discourse while others become its subjects, and secondly to consider how power might work to position *all* social participants in terms of the discourses that purport, and are believed, to tell the truth. It means also that when we consider therapeutic practice, we should not consider the therapist the arbiter or judge of therapeutic "truth" (despite his or her position in discourse as such a judge), but rather its product and its vehicle (c.f., Foucault, 1982): therapeutic discourse requires and creates therapists as its means of application and reproduction. Therapists are positioned in particular (perhaps influential) ways *within* a discourse of truth, and are hence its subjects. As noted by Goldner (1993), "discourses have replaced despots as vehicles of social control" (p. 160).

The status of self-containment as "self-evident truth" is historically and culturally unique (Sampson, 1993), and is inscribed through a variety of contemporary western institutions (e.g., education, the law, religion), which demand and reproduce an individualized subject (Rose, 1998). Thus, in the

contemporary western world, *all* persons are expected to recognize their "individuality", to be self-governing and self-determining, and to act accordingly (Foucault, 1977; Rose, 1998). However, there is evidence to suggest that in many non-western cultures, value is attached to a more socially embedded, collectivist notion of self (e.g., Geertz, 1979; Laungani, 1999; Ochs, 1988). This is not to suggest that all western talk emphasises self-containment while non-western talk always prioritizes more embedded notions of self (Potter & Wetherell, 1987). Indeed, Rasmussen (1999) argues that there may be "multiple views of personhood in a single culture that are conveyed in different kinds of circumstances and by different kinds of discourse" (p. 406). However, it is argued that despite this variation, western institutions construct self-containment as not only possible, but as true and ideal.

This idealization is reflected in the tendency of western institutions to look unfavourably on persons who do not act as if they were self-contained, personally responsible for their own experience, and agents of their own behaviour. For example, courts, schools, professional registration bodies, churches and hospitals tend to look unfavourably on persons who fail to take responsibility for their actions. Thus we find undesirable qualities such as "irresponsible", "unprofessional", "lazy" and "mad" being attributed in such cases. In this way, the elevation of self-contained individualism to the status of truth allows it to be used as "a means of control and a method of domination" (Foucault, 1977, p. 191). That is, the self-containment discourse may inspire the need for a variety of interventions, while simultaneously being used as their justification: to punish a "lazy" child; to sanction an "unprofessional" psychologist; to medicate or incarcerate the "mad". Thus, while we might find, in ordinary social encounters, acceptable talk of experiences, thoughts, feelings as emanating from sources outside of the self, in both western and non-western cultures (Potter & Wetherell, 1987), such talk tends to be systematically undermined in western institutions and the knowledge-disciplines attached to them (such as education, law, medicine, psychiatry and psychology). I argue that the variation in talk to which Potter and Wetherell (1987) refer is suppressed. Similarly, statements reflecting and reproducing self-containment are likely to be privileged in therapy. On the other hand, it is hypothesized that when alternative discourses (i.e., contrary to self-contained individualism) are evident, interventive exercises of power are legitimized, and may even be constructed as "therapeutic".

4.2.2. Therapeutic rhetoric: the development of "therapeutic" discourses

In this chapter, I have chosen to focus on constructionist approaches to therapy, although it will be argued that these arguments may apply to most therapeutic practices. While there are a variety of constructionist practices, they share a view of therapy as a productive practice, in which new discourses of the self are seen as constructed, rather than discovered, in therapist-client dialogue (McNamee & Gergen, 1992). New discourses can make new possibilities visible and new practices possible (Anderson, 1997; White & Epston, 1990), and so new accounts of the self permit the generation of new experiences of the self (Freedman & Combs, 1996).

The question thus arises: What counts as a "therapeutic" self-discourse in constructionist therapies? According to Drewery and McKenzie (1999), the client should be installed as "agent of their own life stories" (p. 138). Similarly, Freedman and Combs (1996) aim to enhance "those aspects of a story that support 'personal agency'" (p. 97). Anderson (1997) suggests that therapy "is about helping people to access the courage and ability to 'move about around things', to 'have a clear view', to achieve self-agency" (p. xviii). For constructionist therapists, personal agency and the authorship of one's own personal stories are required for discourses to be considered therapeutic.

It is perhaps obvious that the preference for storying individual lives such that they reflect agency and self-definition is common to most therapeutic approaches (for arguments to the contrary, see discussion below), and is by no means unique to constructionist therapies. Consider, for example, the following hypothetical statements of a client in therapy: (1) "I feel better now that I've learned to stand up to those who bullied me"; (2) "I feel better now that those bullies have emigrated to another country". It is perhaps unnecessary to argue the point that most therapists, of most theoretical orientations, would value statement 1 above statement 2. Despite the considerable variety of theoretical approaches to psychology, Rose (1998) argues that they share a "common normativity", valuing the individual as self-contained, the locus of thought and action, agents or causes of their own behaviour, and self-determining. Statement 1 reflects such a theory of self while statement 2 does not. Thus, it seems that therapeutically good-enough stories should reflect and reconstruct a self-contained client, responsible for and agent of changes in her life.

However, agency and self-authorship may not always be emphasized, as talk tends to be characterized by variation (Potter & Wetherell, 1987). In this regard, Gergen (1999) suggests: "we harbor multiple narratives, employed on different occasions for different audiences" (p. 174). Variation is celebrated by constructionist practitioners, and is considered a resource for the development of new, preferred discourses of self. However, despite an avowed respect for all points of view (Kenwood, 1999), and an effort to avoid partiality by adopting a stance of "multipartiality" where therapists "take all sides simultaneously" (Anderson, 1997, p. 95), constructionist therapists cannot practice without bias. Not all stories will do, and therapists cannot attend equally to all discursive constructions of the self (Freedman & Combs, 1996). We have to make choices when speaking to another person, in the process inevitably encouraging some forms of talk while suppressing others. Variability may be encouraged in theory, but is suppressed in practice when choices are made about who to talk to at what times, what to talk about, when to respond, and so on. To properly analyse therapeutic philosophies or "stances" (Anderson, 1997) then, we need to explore how variation is managed, encouraged, or discouraged in actual talk. This means that therapeutic stances should be considered, not as attitudes or beliefs, but as performances or achievements. A "stance" must be analysed in terms of how it is practised.

When we focus on what therapists actually say in therapy, the notion of therapy as an art of persuasion begins to re-emerge (c.f., Frank & Frank, 1991). Therapy is a rhetorical endeavour. I use the term rhetoric in Billig's (1990, 1996) sense: rhetorical strategies are argumentative in structure, justifying one position

while implicitly or explicitly criticizing other positions. Billig argues that rhetoric is used in all forms of thinking and conversation, and so on this account, therapeutic work would be no exception. Indeed, in recent years, rhetorical processes in therapy have come increasingly under scrutiny (e.g., Davis, 1986; Kogan, 1998; Stancombe & White, 1997).

The work of Davis (1986) and Kogan (1998) are of particular interest here, because both demonstrate therapists' use of rhetoric to privilege specifically individualized statements or stories, in the context of the considerable variation expected in self-construction (c.f., Gergen, 1999; Potter & Wetherell, 1987). Davis' (1986) close examination of talk between a therapist and client highlighted the therapist's use of persuasion techniques both to undermine the client's account of her problems (as embedded in a host of contextual factors), and to privilege a more individualized version of events. In this case, the problem was transformed, despite some resistance from the client, from being related to her difficult home situation, to being a function of her inability "to express her feelings openly and honestly" (p. 53). This rhetorical relocation of the problem from the outside to the inside thereby makes the problem more amenable to a specifically therapeutic sort of intervention.

Kogan's (1998) empirical study of a therapeutic interaction also highlighted the therapist's use of persuasion to promote certain kinds of talk rather than others. He noted the therapist he studied used a "disciplining of narrative" technique: the employment of rhetorical tactics that privilege "preferred utterances… where 'useful', 'important' and 'therapeutic' statements are evident" (1998, p. 236). This means that certain statements are considered less "useful", "important" or "therapeutic". Both Davis and Kogan highlight the importance of investigating what therapists actually do and say in practice (as opposed to accepting our practice *claims*), and demonstrate how in-session rhetorical procedures can function to privilege stories emphasizing individuality and self-containment.

As Davis (1986) suggests, however, it is not enough that utterances or statements reflecting individuality or self-containment are merely selected for discursive attention. They must be "made real", becoming more than merely "words" spoken in the consulting room. Using rhetorical devices, therapists can facilitate the concretizing of personal agency as the primary theory of a client's self by making this theory both visible and practicable. The rhetorical strategies of reification and ironisation (Potter, 1996; Potter & Wetherell, 1987) may be useful in understanding this process. Reification refers to the prioritising of certain accounts, and the construction of these as objective, true, or real. On the other hand, ironisation refers to the devaluation, marginalization or denial of accounts so that they appear less real and less convincing (Potter, 1996). Together, reification and ironisation strategies may be used to manage variation, suppressing some statements while encouraging others, making visible a coherent narrative. Used together, these strategies can iron out apparent contradictions in what a person says about her- or himself, enabling a view of a coherent, singular, self-contained individual.

In this way, it becomes possible for the therapist, under the influence of the self-evidently true discourse of self-contained individualism (as outlined above), to participate in a much broader exercise of power. By favouring self-contained

accounts (i.e., if this is the case), the therapist inadvertently colludes with prevailing institutional and discursive practices to individualize the person, to mark him or her with this individuality (a perhaps personalized and unique *form* of individuality, but then, this personalization is precisely what individuality/self-containment prescribes), and to render him or her subject to the version of discourse (e.g., psychodynamic, constructionist) in which his or her particular form of individualization might be constructed.

The therapeutic preference for certain types of self-talk does not necessarily involve an overt rejection of other, less preferred talk. Rather, discursive conflict is often resolved by more subtle discursive arrangement. One discourse may be arranged, and thereby minimized, in and by the terms of the other. For example, a depressed client who has improved after receiving both therapy and medication may be seen as minimizing (or ironising) her own efforts and personal agency if she states: "medication made me better". In therapy, such talk can be ironised by promoting talk of the client's deliberate, conscious, agentive use of the "energy boost" provided by the medication (for example) to assess her life and make the changes she needed to make. This construction is preferable because it affords a view of self-agency, while not totally disallowing the positive role played by medical interventions. It therefore has the additional benefit of appearing "reasonable". Statements may be arranged in such a way that personal agency comes to the fore, as the preferred "cause" of change: while medication gave her a boost, she had to do the changing herself.

A co-existence of apparently conflicting discourses may be achieved via discursive negotiations and rhetorical strategies. In prioritising and reifying certain aspects of the story, a suppression of other aspects is achieved. Similarly, constructionist therapists, while ostensibly viewing persons as multiple and variable selves, may suppress variation by favouring an *arrangement* of discourses that minimize or reduce the significance of certain aspects of the account. From the perspective of therapy as a power/knowledge network (as argued in chapter 2), this suggests that knowledge need not be directly imposed on the client for an exercise of power to take place. It is this direct imposition of meaning to which many therapists refer and object in discussions on power (e.g., Carpenter, 1994). Rather, the client may become subject to therapeutic discourse via more subtle forms of argumentation and discussion, involving the rhetorical weaving of ironisations and reifications. But it is argued here that while a *specific* discourse might not be used to objectify the client, there is the possibility that the broader discourse of self-containment - seldom questioned because of its apparently obvious basis in "nature", and because of the general acceptance of the principles of agency, self-determination and authorship – is unwittingly represented and prioritized, becoming an unseen discursive benchmark against which talk might be measured.

This rhetorical view suggests that therapy involves a discursive arrangement of statements, so that aspects of self-containment become increasingly evident. In an effort to ensure that such statements are elucidated, therapists engage in a series of rhetorical manoeuvres, "helping" clients towards a more psychological appropriate – i.e. agentive – theory of themselves. These arguments will now be considered in the light of a particular case.

4.3. Case Study and analysis

The case concerns a family that was referred, by a psychiatrist, to the author at a family therapy clinic. The author's practice was based principally on constructionist frameworks (e.g., Anderson, 1997; Freedman & Coombs, 1996; Tomm, 1987; White & Epston, 1990). Attending sessions were Lionel, a 14-year-old boy identified as the source of concern (referred because of his temper), his mother (Sharon), stepfather (Peter), grandmother (Glenda), mother's sister (Bianca) and myself (Michael). All names, besides my own, have been changed to protect the identity of the family. Consent was obtained to have sessions video-recorded and used for research purposes.

4.3.1. Method of analysis

The first two sessions were transcribed and analysed. Based on Sampson's (1993) arguments, I invoke Parker (1992) to propose "self-contained individualism" as *a discourse*, whose variable presence and operations are considered in the talk between therapist and family. The impact of this discourse is examined via attention to discussions concerning the following three subjects: problem behaviour; attributions of credit/blame for success/failure; and theories of change. Talk around these issues made visible different and variable accounts of Lionel's autonomy, personal agency and self-containment. Following Potter and Wetherell's (1987) guidelines for analyzing discourse, two questions were asked of the text. First, how do speakers construct different versions of events? In this case, we are concerned with how family members, as well as the therapist, rhetorically construct accounts of Lionel's behaviour. Second, what are the functions of these constructions – what do they achieve? Specifically, the ability of accounts to allocate personal credit/blame to Lionel, or alternatively, exonerations from personal responsibility is explored. The therapist's rhetorical management of this variability of accounts is then highlighted and analysed, ultimately in an attempt to identify the minutiae of power operations in the therapeutic arena.

4.3.2. Discursive case material and analysis

In the first session, talk developed around Lionel's early relationship with his mother and grandmother. Sharon and Peter had met and married six years previously, and so Peter had no involvement in Lionel's early life. Lionel was born when his mother was an unmarried 18-year-old. She described feeling unable to cope with the situation, and so her mother (Glenda) had taken over much of the parenting. Sharon had recently begun individual therapy with another therapist, and had discussed these matters in those meetings. The following dialogue took place twelve minutes after the meeting had begun:

Extract 1

Sharon: It came up (in therapy) that I felt like an illegitimate mother.
Michael: Ya, ya.
Sharon: Um… especially as my mom had taken so much of the… the role, and that Lionel sort of did play us up against one… one another.

Lionel: Did I?
Sharon: Ya … I mean unconsciously my boy.
Glenda: Meaning, not meaning to.
Michael: Who's us?
Sharon: (points to herself and Glenda)
Michael: Oh, the two moms.
Sharon: Ya, you know like I would feel that if I gave him a hiding say, or I wouldn't let him have something, or I'd punish him, or whatever… that as soon as I dropped him off with my mom he would tell her and she'd get angry with me, and think 'how dare she be so cruel to my child'.
Glenda: How could she do that?
Sharon: You know what I'm saying?… so he would, I don't know if he ever said I wanted … I think he did, he would say 'I'll tell gran what you're doing… (Bianca laughs) to me'.
Glenda: He actually used to say the same to me: 'Now I'll tell my mom what you've done', if I gave him a hiding for instance, I smacked his bottom or whatever, he'd say 'I'm gonna tell my mom' (laughs).
Michael: So, ya.
Glenda: Which is quite natural because he was seeing us both as the authority.
Michael: It's quite a nifty skill… for a… for a child to pick up?
Glenda: They're clever (laughs).
Lionel: (to Sharon) I'm clever.

While there are a number of points that can be made about the above dialogue, I want to highlight matters pertaining to self-containment in talk about Lionel. Lionel was spoken of as "unconsciously" playing one mother figure off against the other. Glenda and mother were both careful to point out to Lionel that his behaviour had not been malicious or purposefully manipulative. While this has the effect of reducing Lionel's blame for his actions ("meaning, not meaning to"), it also has the effect of reducing his *responsibility* for his actions. His behavioural agency is diminished when he is seen as enacting "unconscious" processes. Glenda further reduces blame, stating that his behaviour was "natural". Accounts of an unconscious and natural playing off of people against each other suggest a lack of personal agency in Lionel's actions. The therapist's statement moves towards a transformation of this account, referring to these actions as "a nifty skill… for a child to pick up". The language used is significant: a "skill" is performed with knowledge and awareness (and "cleverness"), rather than emanating from unknown and unseen unconscious processes. Glenda and Lionel pick up on this statement, referring to Lionel's actions as "clever". This is a move towards locating Lionel's actions as owned, deliberate and agentive: a self-containment discourse is offered.

The following extract is taken from a few minutes later. Lionel had just pointed out that in the family he was usually the one "who has a fit", referring to his anger:

Extract 2

Michael: And it helps?… it helps?
Lionel: Not really, just like…
Michael: What's it designed for, what's it designed to do? If it did work, what would it…
Lionel: To scare… to scare most probably.
Michael: To scare who?
Lionel: Dad and mom.
Michael: And that would make them back off from you…
Lionel: Ya.
Michael: And give you what you want. Okay, and it doesn't really work so well?
Lionel: Makes it worse.

The therapist again introduces a language of agency in this extract. Lionel's temper is constructed as "designed" for some purpose to suit Lionel's aims. This again shifts talk away from his passive, blameless acting out of "unconscious" or "natural" processes, towards a construction of deliberate, agentive behaviour "designed" to benefit Lionel. Lionel works within this discourse, responding that it is designed "to scare… dad and mom". This short statement achieves two important rhetorical effects.

1. It points to some personal control and ownership of his angry behaviour. Lionel designs the behaviour himself; it is not designed for him. Designing behaviour for personal purposes may be contrasted with talk of behaviour being determined by forces outside of, or beyond the reach of the agentive self ("unconscious", "natural", or "just happening"). Lionel's construction of anger as a scare tactic evokes a sense of agency, introducing an element of personal responsibility into his account. While this makes attributions of blame possible, it also introduces the possibility of change through self-government, in a way that anger "just happening" cannot.
2. It points to a specific set of relationships (or targets of his scare tactics) and not others. Earlier in the session, Lionel said that his anger was indiscriminately directed at "everyone… it's just everyone". In this interchange, his account shifts towards a construction of his anger as designed around his relationship with only his parents. Indiscriminate expressions of anger are more easily attributed to forces beyond Lionel's control. Now Lionel suggests that his anger doesn't "just happen", it happens for a reason, and with particular people.

The interactive manner in which this movement towards agency talk was produced is crucial. To the extent that Lionel's talk of a "design" to his anger was made possible by the constraints and possibilities of the questioned posed by the therapist ("What's it designed to do?"), anger-as-designed is a joint production. However, in order for it to be considered *Lionel's* behaviour, with his design/purpose, that is, in order for his behaviour to be considered agentive, the joint nature of that construction must be denied. That is, anger-as-designed must be considered monologically (in Sampson's terms); not as something constructed

in talk (i.e., dialogically) but as something Lionel developed himself. It should be noted that a view of anger-as-designed is more likely to produce blame.

The retention of a monologic construction of anger (i.e., as self-authored) involves an adherence to an individualized discourse of self-containment. It is this discourse that persuades speakers to overlook the possibility that apparently self-determined conduct may have been the product of social and interactive, rather than personal and psychological, processes (c.f., Gergen, 1999; Sampson, 1993). Talk becomes shaped accordingly.

It should be noted, as discussed in chapter 3, that the joint or mutual production of meaning is not an *equal* production, as is sometimes implied by constructionist therapists (e.g., Anderson & Goolishian, 1988; Hoffman, 1992; Roberts, 1998). The constraints and terms of the question asked above ("what's it designed to do?") were set by one positioned as "expert" in relation to another positioned as client, the object of the therapist's gaze and knowing (i.e., knowledgeable) attention. New meanings can be given to Lionel's talk and action to the extent that he implicitly displays the features of malleability and uncertainty; while the therapist's talk demonstrates the quality of a shaping force, opening up ostensibly expert frameworks for the re-classification of Lionel's experiences (see chapter 3). The point is that the primary positions impact on how speakers are heard, and foster the attribution of different "weightings" or levels of significance to their statements.

When talk resumes (immediately following extract 2), focus falls on the fear produced by Lionel's anger.

Extract 3

Sharon: Well, he has scared us… very much.
Michael: Scared you in the sense that he might hurt you, or…
Sharon: Yes.
Lionel: I wouldn't hurt you ma.
Sharon: You have hurt me my boy.
Michael: Scared you, scared you personally?
Sharon: Ya.
Lionel: How?
Sharon: By pushing and shoving.
Lionel: Ah… you know what I think, sometimes I… sometimes I get violent like that because you used to get violent with me a lot, hey.

It is perhaps not surprising that immediately after Lionel's references to the "design" of his anger (in extract 2 - and the associated invocation of personal agency), Sharon for the first time approaches blaming him for his behaviour. We do not know if Lionel felt blamed, but he responds to his mother's expressions by actively relocating the source of the violence away from himself and onto his parents. Lionel here appeals to the common western notion of "childhood trauma" as a mitigating factor in behaviour (Parker, 1998): "Sometimes I get violent like that because you used to get violent with me a lot". The cause of his behaviour is no longer his agentive self, but the violence he suffered as a child at the hands of his parents. In this way, he speaks of his behaviour as determined by forces and practices emanating from outside of his "self".

The matter of Lionel's agency emerges perhaps most clearly in the second session. The following extract is taken from twenty minutes into that session, a month after our first meeting, after all those present had given accounts of how Lionel's behaviour had "improved", and of how he had not displayed any aggression towards anybody, either at school or at home, since our first meeting. Furthermore, Peter related an incident that had occurred at a local dam, where Lionel was told he could not have the money to hire a jet-ski. Peter indicated that Lionel had "negotiated", showing "a lot of maturity, a lot of self-restraint and an understanding", despite being denied the money he sought. Sharon begins the dialogue concerning how these changes had been achieved.

Extract 4

Sharon: I think that some of that is the medication, Lionel has been helped a lot by the medication, um...
Michael: What do you think Lionel?
Lionel: Ya.
Michael: What's the medication helped you to do?
Lionel: Its just, calmed down a lot, and um... I don't know, just I feel more calm and um...
Peter: Less anxious?
Lionel: Ya, less anxious.
Michael: Can you, for yourself, take any credit for what's happened?
Lionel: Ya, I've tried.
Michael: I mean, its not just ... surely its not just passively waiting for the medication to work, there's also something <u>you've</u> got to do about it.
Lionel: Ya, I'm trying.
Michael: What sort of stuff?
Lionel: like um, to keep my calm and not to fight about everything.
Michael: Cos I think one thing, as your dad was, your dad was talking about you negotiating stuff, medication can't make you negotiate (Sharon: mmm mmm [in agreement]), so I'm wondering if there's something about you that's also happening?
Lionel: I...
Sharon: Answer the question.
Lionel: What was the question again?
Peter: Medication can't help you negotiate.
Glenda: Ya, what, what made <u>you</u>..
Peter: What made you negotiate for example that day at the dam on the jetski, what made you negotiate?
Lionel: I dunno, I just did.
Sharon: I think its because the medication is helping him to feel calm, and then he's able to use his natural ability to negotiate and his natural ability to understand other people's points of view, whereas maybe the anxiety and the anger and the frustration and all those other huge emotions clouded his view and he wasn't able to... use those...
Michael: I think its, ya... I think its just important that some some credit be given for his own efforts (Sharon: mmm [in agreement]), rather than... its easy to kind of blame people for things they do wrong and

> then when it comes right we say 'phew, at last its normal now', whereas there's also some effort required, you know... (Sharon: Ya) There's a deliberate attempt to negotiate, for example

In this extract, two conflicting discourses can be highlighted, which are rhetorically played out. Sharon's initial statement regarding the reasons for positive change prioritizes medication. For convenience I shall refer to this as a "medication discourse". In response, the therapist alludes to and then later on speaks directly of Lionel's efforts and personal agency: an "agency discourse". While these discourses need not be mutually exclusive, they differ in their arrangement or prioritising of statements. These are rhetorical arrangements, producing different discursive effects in relation to Lionel and his "improved behaviour". Sharon's statement ("I think the medication calms him, and then he's able to use his natural ability to negotiate and… understand other people's points of view") threatens to displace an agency discourse, which emphasises achievement-through-effort, and therefore promotes congratulation. Thus, her statement removes any need for applause, constructing Lionel as "naturally" reasonable and understanding. Constructing Lionel's "goodness" as something he is rather than as something he does functions discursively to remove personal agency as a cause: action/performance is more easily tied to an agency discourse than to some "natural" but abstract character disposition.

The therapist's discourse of personal agency establishes different priorities: "medication can't make you negotiate". This statement undermines the medication discourse by suggesting: (1) there are some things medication cannot do; (2) negotiation is important (as the therapist specifically selects this issue, and not others, for discussion) and cannot be accounted for by medication; (3) and that therefore some other explanation is required. The question implicit in the therapist's comment allows little discursive room for any meaningful answer that does not refer to personal agency. Language is managed to powerfully undermine the primacy of medication in Lionel's changes. The statement "medication can't make you negotiate" alludes to what Lionel has *done*, and therefore makes it possible to view Lionel's "improvement" as a personal *achievement*, rather than passively acquired through the intake of medication.

Sharon, Glenda and Peter contribute to the therapist's doubts about any causal link between medication and negotiation by restating the question and repeatedly encouraging Lionel to answer it (in extract 4). In so doing, they consensually construct doubt regarding the medication discourse's primacy, allowing for movement towards the construction of an alternative account of Lionel's actions. The achievement of consensus – in this case, consensual doubt – can significantly influence the acceptability and believability of accounts (Edwards & Potter, 1992).

By raising doubts about its ability to properly account for change, family members join the therapist in ironising the medication discourse, thereby undermining the passive position into which it invites Lionel. These maneuvers do not remove medication from discursive consideration, but retain it as a rhetorical counterpoint against which a more active, agentive account may be constructed and strengthened. The medication discourse is thus made serviceable to a preferred account. The initial presence and devaluation of the medication

discourse make an alternative account seem necessary. In the process, the more active account of change made available by the therapist is rendered even more plausible. Thus the passive position constructed for Lionel by the medication discourse may be seen, in Sampson's terms, as a "hidden dialogic partner": its role in the promotion of a more plausible account – of Lionel's conduct as performed and self-determined – is denied. The ironisation of the medication discourse, and the rejection of the passive position it suggests for Lionel, allows for the reification of an agency discourse, which then becomes the "real" reason for Lionel's changes.

Furthermore, Lionel's agency is seen in self-contained terms: as something Lionel did, rather than something that emerged out of dialogue. In other words, the therapist does not share credit for its construction in talk, but perhaps – at best – shares the credit for *allowing it to emerge* as if it were latent, hidden somewhere already "within" Lionel. Indeed, in a later session, Peter stated: "I think this whole process has helped us see what we weren't seeing in Lionel, and in us. So now we can sort of build on it." This implies that while "it" (Lionel's "reasonableness and maturity") was not seen, it was there prior to our dialogues. Similarly, Sharon's talk of Lionel's "natural abilities" constructs his "improved behaviour" as emerging, not from dialogue, but from his "interiority". This is consistent with a monological view, in which each individual is constructed as self-contained, drawing on their own qualities and properties to effect change. A view of the *joint* construction of agency is not permitted, and cannot make sense in a discourse of self-containment. And so the therapist's contribution is constructed as one of assistance in revealing the truth about Lionel, showing the family what was already there, but which they could not see.

On the other hand, it would be unlikely, and would perhaps seem inappropriate, for Lionel's personal agency to be discussed in dialogical terms: as constructed or invented through dialogue, or indeed in discourse, rather than as an ontological or psychological reality. Such dialogical talk threatens the very idea of agency, of persons being the primary cause of their own changes. While constructionists view therapy as productive and generative (rather than based on the discovery and reinforcement of already existing self-contained properties), the dialogical production of *personal agency talk* is difficult to talk *about* in actual talk between therapist and client/family, without simultaneously undermining that talk. Instead, dialogical processes tend to be denied or overlooked, and so the changes realised by the client, and the therapist's contribution to these, tend to be defined in terms of self-containment: monologically as opposed to dialogically. That is, the construction and reproduction of personal agency – as long as these are to be therapeutic goals – must necessarily be understood as personal, agentive and self-contained achievements.

4.4. Discussion

The analysis of therapy talk is instructive in an examination of power. In Foucault's terms, talk is considered the terminus, or final destination of power in the therapeutic setting. This chapter argues that therapy talk should not be considered only a process in which problems are uncovered and solutions found. It is argued that the therapeutic achievement of understandings and pathways to

solutions involve a considerable amount of persuasion (c.f., Davis, 1986; Kogan, 1998; Stancombe & White, 1997). "Therapeutic" persuasion can be seen here, to invoke Foucault again, as a discursive practice – shaped in this case by the discourse of self-containment – that works in a more or less systematic way to produce "the objects of which it speaks": agency, self-determination, blame (by others and self), credit, a sense of responsibility, etc. These are not merely constructions, but become *real* in the social domain insofar as people treat each other, and themselves, accordingly; for example, blaming Lionel for his "failures" or congratulating him on his "successes". I suggest that this rhetorical discursive practice may not only follow the lines of the therapist's preferred theory or even the client's preferred narrative (c.f., Seikkula, 2000; White & Epston, 1990) – although this may the case in some practices – but may be more fundamentally guided by a widely accepted and hence invisible western discourse of what it means to be a human being: an individual; a possessor of internal qualities and attributes; a knowable entity; a being that can be credited or blamed; a self-determining and self-authoring agent. These "qualities" by no means define humanity (c.f., Geertz, 1979; Holdstock, 2000; Sampson, 1993), although it seems that they have come to define the contemporary western person. They are qualities prescribed by the individualizing discourses, practices and technologies in which we are immersed. Their seemingly self-evident nature is associated with a relative inattention to the idea that there may be other ways of constructing personhood (Gergen, 1999; Holdstock, 2000), and hence, other ways of being a person. This issue will be more specifically addressed in the following chapter with reference to the tension between psychologised self-containment discourses and feminist discourses, in accounting for the production of and/or solutions to problems.

While I have focused here on constructionist therapies, these arguments may apply to a wide range of therapeutic approaches. However, it should be noted that many family therapy approaches understand persons as relationally embedded rather than as self-contained (e.g., Haley, 1976; Hoffman, 1985; Minuchin & Fishman, 1981). In developing "a project to disappear the individual" in family therapy, however, Hoffman (1992) warns against replacing "the individual unit with the family unit" (p. 10), a move that simply extends self-containment to the level of family, and thereby fails to adequately address therapeutic dialogical processes. Instead, she and others (e.g., Andersen, 1987; Anderson, 1997; McNamee, 1992; Roberts, 1998) adopt a constructionist framework and see clients not only as relational figures, but also importantly as relationally *constructed.* In other words, client self-talk in therapy is seen as co-created out of therapist-client dialogue (or between clients and others), rather than as a product of individual and psychological self-contained processes.

However, possible exceptions to this bias for self-containment are cautiously noted: it is easier to advocate dialogical processes in theory than in practice (Golann, 1988). As demonstrated in this chapter, talk might be "co-created" in talk between therapist and client, and acknowledged as such (at least by the therapist), but this does not preclude the emergence and privileging of talk and practices consistent with a discourse of self-containment. Clients do not typically consider emergent ideas and practices to be "joint productions". The therapist's preference for a view of talk as relationally constructed does not mean

that relational – as opposed to self-contained - discourses will be *produced* in that interaction. To use Sampson's terms, monological discourses can easily be produced out of dialogical processes. And this is what matters from the perspective of power: the *products* of therapeutic talk, rather than the philosophical stance or attitude of the therapist. Again, therapist intentions are not a good way to measure what actually occurs in therapy. This is why claims to have overcome the perceived limitations of a self-containment discourse should be carefully examined with respect to the discursive and rhetorical features of actual talk between therapists and clients.

Rhetorical analyses of therapy talk permit a detailed view of the effects and achievements of language used in therapeutic dialogue (Stancombe & White, 1997). Thus, a clearer view of the therapist's rhetorical strategies may be established, and the persuasive aspects of the construction of "preferred", new or therapeutic discourses made visible. Indeed, the relationally oriented family therapies cited above tend to avoid seeing the therapist's role as one of persuasion, preferring to focus on therapist-client *collaboration* in the co-construction of meaning. However, as mentioned above, collaboration does not necessarily imply equal input into the discourses developed in the interaction; and indeed any prior construal of the relationship as collaborative already constitutes an exercise of power through the associated positioning requirements exacted on the client (see chapter 3). By constructing the process as one of collaboration, there is the risk that real power differences, and the degree to which persuasion occurs (even unwittingly), may become obscured. Goldberg (2001) provocatively calls this dishonesty, and a failure of moral integrity. Golann (1988) also maintains that the emphasis on egalitarian stances conceal power relations, and "may represent wishful thinking about equality between therapist and family" (p. 62). Rhetorical analyses highlight a different kind of dialogical process, in which contested meanings and the therapist's use of persuasion in the shaping of therapy talk can be made salient. In other words, rhetorical analyses permit a view of the relationship between dialogue and power.

A focus on rhetorical strategies may therefore point us to problems we might otherwise gloss over in our work. If we assume that therapy is a collaborative endeavour, and that therapists are well-meaning practitioners of a benevolent craft, we may be predisposed to a focus on the therapeutic effects (e.g., Lionel's development of new ways of talking) of our work. While such an analysis may be useful in many respects, it risks obscuring from view both the persuasive aspects of therapy talk and the biases (such as unstated ideals of what it means to be a person) that may be implicit in our practices.

I have argued that one of these biases involves the therapeutic tendency to privilege agentive, self-authoring discourses of self over discourses in which individualism is denied, undermined or de-emphasized. Nevertheless, whether working with individuals or with families, constructionist therapists have attempted to destabilize individualistic notions of selfhood, favouring a view of persons as dialogically constituted. It seems, however, that shedding the privileging of self-containment in actual therapy work may be a very difficult task. In particular, the value placed on "personal agency" by numerous constructionists tends to promote a view of the person as the locus and creator of meanings, feelings, decisions and behaviours. Thus, when we consider Sampson's (1993)

association of self-containment with western views of personhood, it seems that therapeutic practices which privilege personal agency may reproduce certain aspects of dominant western culture.

There is one final important question to consider, with specific reference to the issue of self-containment: So what if the therapist biases towards agency and self-authorship? What is the problem in this? There are at least three interrelated problems. First, there is the obvious problem that this poses for the local therapeutic relationship. It suggests that therapy is a relationship of persuasion, in which discourses of self-containment, to the extent that these are prioritised by the therapist, may in time (and not necessarily with deliberate intent) come to ironise, capture, and modify or transform those of the client. The natural variation of talk (Potter & Wetherell, 1987) might be suppressed in therapy, in favour of a more coherent and disciplined account of self-containment. To the extent that this is the case, therapy cannot be accurately construed as a collaborative endeavour. In fact, this comes very close to what Kuyken considers an example of a "subtle interpersonal *abuse* of power": psychologists molding clients "in imitation of themselves" (1999, p. 23, emphasis added). In principle it could be argued that molding clients in imitation of *a preferred discourse* might, in Kuyken's terms, be considered in the same way. And yet this may be precisely what seems to occur in most forms of therapy. The element of persuasion, together with the apparent entitlement assumed by therapists to overtly *or* covertly interpret client behaviour (as discussed in chapter 2), and the therapists positioning as expert-knower, all conspire to undermine and complexify attempts to democratize therapy. I suggest that under these conditions, claims of the achievement of mutual (in the sense of "equal"), egalitarian and collaborative practices should be considered with caution.

Secondly, as alluded to earlier in this chapter, there is the problem of culture. While the issue of agency in different cultural groups is an as yet unresolved and contentious one (c.f., Jenkins, 2001), there is the risk that the individualization that tends to be promoted in therapy practice is not suited to persons of all cultural groups. This possibility has been recognized, and attempts have been made to create more culturally sensitive therapeutic practices (e.g., Laungani, 1999). Given its complexity, I will not attend to this issue in any depth, although I would suggest that for future study, there is a danger to be considered: that in the very process of constructing cross-cultural therapies, therapy might become, *once again*, an unwitting tool of cultural reproduction.

And thirdly, related to the above, the final difficulty in the bias for self-containment may lie in the possible confluence of tactics between the therapist's (micro) exercises of power and the more generalized circulation and institutionalization of discourses and practices that function to individualize the population in the contemporary western world (c.f., Foucault, 1977; Rose, 1998). More bluntly stated, there may be a significant correlation between the practices of individualization witnessed in therapy (e.g., as described in this chapter), and the broader discursive and institutional processes that require individuality of us. It means that therapy may be a form of government: perhaps gentle, empathic, warm and well-meaning, but nevertheless a technology for the reproduction and government of individuals. This will be further addressed in the next chapter. But for now it can be noted that part of the problem is the inevitable silencing of

alternatives that accompanies the multiplication and proliferation of individualizing therapeutic languages and practices. It then becomes easier for clients, given the prevalence of individualized and psychologised discourse in everyday practices and institutions, to assimilate, intensify and (with the help of the therapist) apply these discourses to themselves in therapeutic practice. These two issues – the silencing of alternative discourses, and the construction of subjectivity in accordance with broadly defined therapeutic discourse - will be considered in more detail in the following chapter.

4.5. References

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CHAPTER FIVE
POWER, DISCOURSE AND THE CONSTRUCTION OF SUBJECTIVITY[5]

5.1. Introduction

This chapter considers, through a detailed case study, the way in which power can work together with discourse (or knowledge) to promote specific kinds of subjectivity. In Chapter 2, I discussed the construction of clients as objects of knowledge, and the resulting therapeutic "incitement to discourse" this makes possible. Therapy was described as a site of intense meaning-making, reinforced and focussed by the directionality of the therapeutic gaze (i.e., on the client). It was argued that this very basic process – in which any and all client actions may be "put into discourse", or subject to interpretation - is both the result of, and also predisposes to, a power relationship that *enables* the discursive shaping and structuring, in innumerable ways, of the course of the therapist-client interaction. Chapters 3 and 4 considered, respectively, the role of the primary therapeutic subject positions and of talk, in this shaping. Therapeutic talk is not appropriately considered the product of "collaboration" or "co-construction" (in an egalitarian sense), but the product of discursive shaping through (1) the culturally maintained construction of fixed and institutionalised therapist and client positions, and (2) procedures of rhetoric and persuasion. It is suggested that the *form* of the structuring discourse – the "content" of therapeutic meaning-making and interpretation – may easily converge with prevailing western institutions and discourses of self-containment. Clients may thereby be encouraged by therapists to talk about themselves and their problems in self-contained, individualised terms. But, as Foucault points out, power does not only work through imposition by one on another; it is most effective when the other becomes subject to it "by a conscience or *self*-knowledge" (1982, p. 212, emphasis added). In other words, power works most efficiently when it no longer *has* to be imposed; when the discourses to which it is attached become accepted as truth by both (or all) parties; that is, when power is concealed.

Thus, this chapter extends the preceding analyses by considering how therapeutic discourses may induce the client to construct *herself* as a psychologised and hence individualised object of knowledge, and thereby produce a therapeutically consistent subjectivity. I use the example of a young woman diagnosed with bulimia nervosa, who becomes the object of a variety of therapeutic strategies and discourses, which facilitate, despite initial resistance, her construction of herself *as* a bulimic. I aim to demonstrate that a person with certain eating practices may be conscripted, via relations of power and strategic persuasions, into a subjugation (or ironisation) of her own account of herself, allowing for a more therapeutically consistent, and self-contained, account to emerge and be reified. But Foucault (1982) and Parker (1992) suggest that local knowledge applications may be conditional upon, and also feed back into, strategic discursive relations at a cultural, societal and institutional level. Thus, in an extension of the discourse analytic study presented in this chapter, I will also

[5] Chapter based on: Guilfoyle, M. (2001). Problematizing psychotherapy: The discursive production of a bulimic. *Culture & Psychology*, 7 (2), 151-180.

explore how the very therapeutic knowledge of bulimia to which the client becomes subject also involves a subjugation of *other* (i.e., extra-therapeutic, lay and professional) accounts – accounts that precede and are external to the therapeutic relationship. In particular, the marginalization and domestication of extra-therapeutic feminist discourses will be addressed, before considering how these discourses – were they to be productive – might construct a different form of subjectivity, and a different set of power relations, specifically with respect to the client presented.

It has been argued in the previous chapter that therapy may, to a large extent, rely upon and reproduce self-contained individuals. This view of the person has permitted the emergence and expansion of a host of disciplines or practices – such as psychology, psychiatry, psychoanalysis, and therapy – that reify and reproduce self-containment. This network has been labelled the "psy complex" (Ingleby, 1985): "the network of theories and practices concerned with psychological governance and self-reflection in western culture" (Parker, 1998, p. 68). The discourses produced within this network – though divergent in many respects – may be termed "psy discourses" to the extent that they share in the construction of persons as psychologised, self-contained *individuals*. This term (psy) will be used in this chapter to highlight a specifically psychologised form of self-containment, and to draw attention to therapy's location within a network of ways of knowing and doing that are privileged in our culture and institutions (Sampson, 1993; Rose, 1998), and which discursively constitute and capture the problem of bulimia. By distinguishing the psy discourses, I also evoke and mark their distinction from alternative, non-psychologised ways of knowing, such as a politicised feminism – which, it will be argued, is ironised and robbed of its potentials to produce alternative discursive practices around the problem of bulimia.

It should be noted that this examination is not in any way an attempt to develop a new or existing theory of bulimia. Rather, the aim is to highlight the subjugating effects of the application of therapeutic knowledge, by and with respect to a person who has been thus labelled in her social network, as well as by professional mental health workers.

5.2. Conceptual issues

5.2.1. The discursive production of subjects

In this section, I focus on Foucault's account of the relationship between discourses and subjects, before considering the role of the psy discourses in our culture, and the relations of power all of this makes possible in therapy practices.

In considering what it means to be a person, Foucault's later work oriented around his professed interest in "the constitution of the subject as an object for himself (sic)" (Florence, 1998, p. 461). Foucault assumes no a priori human subjectivity. Nevertheless, the individual is considered capable of being active in her or his constitution, relating to her- or himself as an object to be known, and capable of resistance against forms and forces of domination. The person constructs his or her position in discourse, and within a network of power relations.

For Foucault, we cannot separate what people say from what they do. And so, to reiterate, discourses may be defined as "practices that systematically form the objects of which they speak" (1972, p. 49). They are not just words to describe things, but are in themselves practices; they are ways of doing, that allow for certain actions and not others. In the process of their articulation and practice, they construct their objects, delineating what can be seen, spoken about and acted upon. This productivity, as was noted in earlier chapters, is made possible by the strategies and mechanisms of power associated with discourse. For Foucault (1980), power "produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression" (p. 119). Thus, power is not something to be held or owned, but is exercised throughout society. It can produce subjects and subjectivities, in and through discourse.

Thus, people can become installed (and install themselves) into subject positions within discourse. These positions exist within a network of power relations, allowing for the constraint or facilitation of certain experiences and actions (Willig, 1999). However, the operations of power involved in the production (and transformation) of the subject and its position within discourse are to some extent concealed. According to Foucault (1990), the concealment of these mechanisms is a necessary condition for power's success, and makes its use tolerable. On this account, the concealment of power's techniques reduces the possibility of resistance, while its exposure might evoke protest and confrontation. This point is pertinent to this chapter, and is relevant to an understanding of the strategies and techniques of therapy.

Despite this concealment, however, resistance is possible. For Foucault (1997a), there is always a "degree of freedom" in power relations (p. 292). The potential for protest is immanent in power relations, and without it transformation could not occur. The forms taken by resistance can vary considerably, each specific to the situation against which it emerges (Foucault, 1997b, p. 168). In the case of therapy then, the client has some choice regarding which discourse to situate herself within, and is able to construct herself via what Foucault (1997a) called "practices of the self" or "technologies of the self" (p. 291): she is able to work on herself, think about herself, and act in relation to herself in a variety of ways, but always from within discourse. She is able to position herself in alternative discourses to that employed by her therapist. For example, she may assert that her being late is not a matter of unconscious resistance, or avoidance, or a sign of her depression, as may be suggested by her therapist, but a matter of having to find someone to take care of her children. What is significant about therapy, as highlighted in chapter 2, is that *some meaning will probably be required* to account for her actions. In the therapeutic incitement to discourse, the client will have to elaborate, or have elaborated for her (perhaps even covertly, but nevertheless influentially – see chapter 2), some meaning around (for instance) her lateness: therapy is not a place in which these things can be easily dismissed as insignificant. This very requirement – regardless of which discourse they eventually settle on - intensifies the therapeutic gaze, and reconstructs the client as an object of knowledge, ultimately (as shall be demonstrated) *for herself*. Nevertheless, within that situation, let us consider her positioning

options. The different discourses presented above imply different subject positions – on the one hand as being in some way "psychologically resistant" (against the therapist's interpretations), and on the other perhaps as "protective parent". Her assertions are elements of practices of the self, through which she discursively constructs her experience and her identity. Foucault (1997a) calls these points of resistance "practices of freedom" (p. 284). They constitute protests against the subjection proposed by a particular and unwanted discourse.

The client's refusal to see her behaviour as psychologically inspired or determined is important, since it is here that she begins to assert her own mode of self-knowledge in contrast to the therapist's construction of her conduct. Such refusal, or saying no, is "the minimal form of resistance" (Foucault, 1997b, p. 168), and it can be enhanced by its elaboration into a new discourse. In this way, resistance also has the potential for a more positive, creative form, enabling the generation of new discourses and practices (Foucault, 1997b). The client's assertions could then mark the beginning of a new discourse, elaborating, for example, on how caring for her children assumes primacy over the therapist's interpretations regarding her time keeping. Such developments undermine the interpretation of psychological resistance. It is important to note that this does not remove power from the therapist-client interaction, since power is integral to the social arena. Rather, the client's refusal has the potential to produce a different set of power relations between herself and therapist, via the construction of an alternative discourse permitting different subject positions. Thus, her discourse might propose limits to the applicability of the therapist's knowledge. Importantly, her refusal also threatens to expose hitherto concealed mechanisms of power in therapy.

However, therapists are trained to employ strategies to address a client's refusal to psychologise her conduct, thereby limiting the possibility of shifting power relations via the subjugation of new, extra-therapeutic discourses. Thus we may obscure the political practice of refusal by investing it with more psychological or therapeutically accessible meanings. Turning political refusal into a psychological matter is an effect of power. It is on the basis of a pre-existing power relationship that such discursive transformation becomes possible and productive. And yet it is through this transformation that the mechanisms of therapeutic power become concealed. Refusal is then constructed as a psychological process within one person (the client), rather than a political struggle between two persons. Thus transformed, *psychological* resistance is both expected and well researched (e.g., Messer, 2002; Newman, 2002; see Garfinkel, Garner & Kennedy, on eating disorders and the "refusal to cooperate" [1985, p. 347]). Perhaps then, as the rhetorical work of therapy is conducted the client starts to question why she hadn't found a child-minder earlier in the week, and begins to wonder if she might indeed be "angry", or "avoidant", or "depressed" (or whatever discursive object is made visible) after all. In this sense, and as noted in chapter 3, she becomes uncertain and potentially malleable, and her experiences are readied for re-classification. In this case, her political resistance (to the therapeutic discourse and the persuasion associated with it) is rendered mute, the political strategies of therapy become obscured from view, and she begins to construct herself as an object to be known through, and hence she becomes subject to, some variety of therapeutic discourse. She thereby

constructs aspects of a new, altered identity for herself. As her questioning continues, she develops her thinking about herself in psychological or therapeutically consistent ways, and in so doing she begins to be tied, and comes to tie herself to this identity "by a conscience or self-knowledge" (Foucault, 1982, p. 212).

It must be noted that such an outcome is by no means inevitable, and resistance to such subjectification could continue. However, (and as suggested in chapters 2 and 3) this might limit the extent to which therapy could proceed, given that therapy requires "a kind of self that would be able to appreciate that discourse and act in an appropriate way" (Parker, 1998, p. 66).

The political nature of the therapist-client relationship must be seen as itself structured by the prominence and widespread infusion of therapeutic and related (i.e., psy) discourses in the contemporary western world. Psy discourses enjoy a position of privilege with respect to its clients, partly by virtue of its subjugation of alternative, extra-therapeutic accounts of the person and his or her conduct (the matter of the marginalization of alternative discourses will be discussed below). This privileged position enables a power relation with regard to the client, which will differ from that which may be reproducible within the lay non-expert community. But as previously noted, it is not just therapists who have access to therapeutic discourses. These ways of knowing have permeated into common-sense, western notions of the person, providing techniques and a language for everyday individual self-knowledge and self-government, producing individualised and psychologised subjectivities.

5.2.2. The historical and cultural emergence of the psychological subject

The psychological subject is a western phenomenon, located in a particular point in history. As previously indicated, Sampson (1989, 1993) refers to this person as a "self-contained individual": according to Geertz (1979) a peculiarly western phenomenon. According to Sampson, this individual became a political and economic focus in the 15th and 16th centuries. It meant that people were able to break free of their communally specified roles, becoming instead "self-determining, autonomous sovereigns, authors in charge of their own life's work… the central actors on the social stage" (Sampson, 1989, p. 915).

Within the context of this historical development, the individual came to be known as an embodiment of various dimensions, giving rise to early developments in the human sciences, such as biology, medicine and psychology. For Foucault (1977), these are some of the disciplines that culminated from the surveillance of the individual, and the objectification and delineation of entities such as the body, the psyche, subjectivity and the self. Historically, these sciences have been "intrinsically tied to programmes which, in order to govern subjects, have found that they need to know them" (Rose, 1990, p. 105). Psychology was thus provided the necessary historical conditions for its emergence and development, building on people's recognition of their own individuality. Moreover, it provided a set of techniques and a language through which persons could practice self-government and self-regulation. And so while psychology cannot claim to have invented the individual, it was – along with other technologies, such as the confession (Foucault, 1990) – constructive in its

complexification, filling the individual with learnings, needs, drives, desires, an unconscious, and a whole complex of psychic forces. Bulimia nervosa and its personification, the bulimic, is one product of this complexification, being constructed in terms of such psychological characteristics and complexes (to be elaborated below).

Being so tightly infused with western modernity's requirement that individuals be self-governing and self-regulating, knowledge of the individual as a psychological being had to be practised by the lay community. Thus the psychological subject became a given, a social fact. People in the western world "recognise" themselves not simply as individuals, but as psychological beings (see Rose, 1998; Sampson, 1989). (It should be noted that alternative, non-western theories of self as socially situated have been developed by authors such as Vygotsky [1981] and Bakhtin [1984]. Also in western academia, constructionist authors such as Gergen [1999] propose a formulation of self as relationally and socially constructed; Harre [1993] argues for a discursive construction of self; and Hermans [e.g., 2001] sees the self in dialogical terms.) However, despite this apparent widespread assumption of individuality, a therapist's recognition of "psychological" processes will differ from that of a non-expert. Historically, western culture has become associated with the development of scientific and "knowing" discourses and practices relating to the person, precipitated by the need for proper governance (Rose, 1990). Experts are therefore distinct from non-experts not simply in terms of what they know, but also in terms of what they can do, as persons deriving legitimacy "from their claims to tell the truth about human beings" (Rose, 1994, p. 139). This issue requires some elaboration.

5.2.3. Common sense and therapeutic discourse

According to Parker (1999), "psychological knowledge is now part of the structure of common sense" (p. 26). But Parker and others (e.g., Moscovici, 1998) make clear that this is not a unidirectional flow of knowledge: common sense and expert knowledges mutually influence and transform each other. Thus psychological knowledge (and its derivative, therapeutic discourse) builds to some extent on common sense knowledge, just as psychological and therapeutic distinctions (such as depression, self-esteem and bulimia) become categories for common-sense employment. Nevertheless, there are inevitably transformations as knowledge passes from one domain to the other. Duveen (1998) states: "(a) representation… is not only a way of understanding something, it is also always a way of not understanding something" (p. 461). (It should be noted, following Potter and Edwards [1999] that I use the language of "discourse" rather than of "representation", to (1) emphasise the constructive rather than "sense-making" nature of representations; and (2) to encourage the visibility of activity or practices.) Duveen's point thus raises the question: What is it about an expert psychological discourse that common sense does not understand? I will focus on one possible answer to this question: non-experts, by definition, should not be able to grasp the object's apparent psychological complexity.

For Moscovici, "(t)he purpose of all representations is to make something unfamiliar, or unfamiliarity itself, familiar" (cited in Smedslund, 1998, p. 450). While some familiarity is indeed fostered by a common sense psychological

discourse of a problem like bulimia (knowing *that* it is psychological or has psychological components), its complexity is highlighted, raised for attention, by its very definition as an expert issue. A proper, comprehensive, or working understanding of bulimia is therefore excluded from the lay public, and the possibility of effective local, non-expert intervention is undermined. When a problem is located in an expert therapeutic discourse, the action suggested for common sense knowers is to refer and defer to expert knowers, rather than to mess around with something that cannot be properly understood by non-experts (as we shall see in the case below). Common sense is effectively disqualified as an appropriate means for structuring and effecting intervention for a specialised problem like bulimia. This disqualification might be rationalised as reflecting different levels of specialist knowledge, but it is more than this. Disqualification is a political strategy by which the two groups are distinguished: it reproduces, for therapists and other psy practitioners, a position of privilege with respect to networks of power (e.g., relations with other health and mental health institutions and experts, as well as, significantly, with legal and formal political systems) that subjugate and minimise common sense knowers.

The claim is not being made that bulimia is always constructed as a psychological phenomenon by persons of current western culture. Nevertheless, it is comfortably located within the territory of the psy disciplines and practitioners. The fact that it is encouraged to be seen as involving key psychological components by the multitude of proponents of psychological and therapeutic treatment of this problem, and that it is reified as such in an entire network of institutions, practices and discourses, points to the significance of these issues.

5.2.4. Psychologised knowledges about bulimia

The psy discourses, to articulate a tautology, are distinguished by their "psychological approach". Gergen has argued that even psychologists who focus on behaviour rather than the "mind" still understand human behaviour as "determined by or… dependent on psychological processes" or mental states (p. 240). But what do we mean by "psychological" approaches? While there are a plethora of disparate approaches and discourses available for the construction of the person, there is a sense in which they tend to share a "common normativity" (Rose, 1998, p. 3). Psychological and therapeutic discourses share ideals of the individual as self-knowing, bounded and autonomous, "the locus of thought, action and belief" (Rose, 1998, p. 3). Again, I will draw on Sampson's notion of the self-contained individual to identify this normative standard. The construction of psychological "objects" – concepts and distinctions to think oneself and one's relation to these ideals – is an important part of the achievement of such individualisation. These ideals constitute a normative standard against which persons such as the bulimic may be contrasted.

The very construction of the category of the bulimic depends on such individualisation: it linguistically distinguishes an individual, the "container" of bulimia. As such, bulimia is more than the display of behaviours such as bingeing and purging, but is also a label that refers to the individual's "interiority" (to use a term from Rose [1998]). The bulimic is thus seen to house a variety of psychological objects deemed relevant to the performance of these behaviours.

This process of interiorization is important in many forms of therapy (but not all – e.g., certain family therapy approaches may claim to be exceptions, although, as noted in chapter 4, even where relational processes are theoretically highlighted, talk consistent with psy and self-containment is not precluded): the discursive location of psychological objects within the bulimic container facilitates her subjectification to a psychologised discourse of her conduct and of herself. In the process, she is afforded particular subject positions within a psy discourse, which may (amongst other things) undermine her self-government, and point to the necessity of expert interventions.

What psychological objects is the bulimic seen to contain? She has been described as having low self-esteem (Peters & Fallon, 1994), emotional lability (Garfinkel & Garner, 1982), tendencies to impulsivity and depression (Kaplan, Sadock & Grebb, 1994), a distorted body image (Peters & Fallon, 1994), ambivalence around her sexual identity, and difficulties around sexuality generally (Abraham & Llewellyn-Jones, 1997), and often questions about sexual abuse are raised (Hodes, 1995; Wooley, 1994). Furthermore, "affective illness and personality disorders" are "psychiatric disorders" that have been associated with bulimia (le Grange & Ziervogel, 1995, p. 478). The bulimic may also be considered to have a narcissistic personality structure (Farrell, 1995). In many cases, she is considered to have poor judgement and insight (Abraham & Llewellyn-Jones, 1997).

This list offers examples of the multitude of psychological objects that allow for the construction of a complex and psychologized bulimic. These are some of the directions in which therapists are entitled to orient their therapeutic talk. While therapeutic and theoretical approaches may differ, they share an interest in the relations between such (and many other) discursive categories and the person of the bulimic. Together, psy discourses provide a range of possible accounts precluding notions of the bulimic as "psychologically healthy". The aim is to enable some variety of "psychological" or "mental health", and so interventive work tends to orient around this normative standard. However, a client may deny the problematic nature and psychological properties of bulimia, and so some form of resistance (i.e., as protest against power) may be encountered. These protests amount to a refusal to be defined or tied to an unwanted discourse, and a struggle for the retention of a particular subjectivity, located in a discourse that may be inconsistent with psy's preference for a certain kind of being (the self-contained individual).

As noted above, Parker (1998) indicates that therapy relies on a "kind of self" able to work within and act in accordance with such discourses. Therefore, for therapy to proceed, a psychologically or therapeutically appropriate – self-contained - account must be rendered (see e.g., Farrell, 1995), the very least condition being that the client take personal responsibility for her actions. To address resistance then, a series of rhetorical practices (c.f. Billig, 1990, 1996) may be employed in therapy. As argued in chapter 4, a view of therapy talk as rhetoric is useful for understanding therapeutic operations of power, which risks exposure when a therapist faces a client's refusal to construct her behaviour in a manner consistent with a discourse of self-containment. Thus, Stancombe and White (1997) ask: "How do therapists utilise rhetoric in persuading and moving clients to alternative understandings?" (p. 26). For the purposes of this paper, this

question might be developed thus: What rhetorical strategies might a therapist use to overcome possible resistance, conceal power operations, and persuade a client to know herself in a manner consistent with a psy discourse?

It must be noted that the normative standard of self-containment is being increasingly challenged, as discourses of culture, feminism, social systems and spirituality (to name a few) have become impossible to ignore in the construction of human beings. These discourses are seldom permitted to undermine the more predominant psychological and individualised discourses, but rather serve to reinforce and expand the parameters of the latter, extending its scope of influence. Psy discourses seem to place outside of acceptability accounts that threaten to subjugate psy discourses themselves. Thus, as new ideas and interventions are assimilated, they risk being neutralised in their appropriation by the psy discourses (Burman, 1999). One effect of this is that psychological and therapeutic discourses can now "speak" to more people, as these alternative discourses are incorporated into a new and apparently more comprehensive set of therapeutic discourses. The subjugation of alternative discourses has profound implications for the therapeutic work we are enabled to do: opportunities for subjectivity offered by non-psy discourses, which threaten the privileging of self-containment, may be lost. (Feminist discourses, and the possibilities for subjectivity they can produce, will be discussed below.)

Therapeutic discourses prescribe a complex of psychological objects and techniques for the production of the bulimic, while simultaneously subjugating other possible accounts. As stated above, therapy may involve considerable rhetorical work to achieve these effects. This may involve countering resistance by promoting a self-contained psychological interpretation, while simultaneously minimising alternative accounts (including that of the client). But more than this, as a complex social interaction, the continuation and tolerability of the therapist-client relationship may also require that the operations of power involved be at least partially hidden from view. These issues will now be considered in greater detail in a case study.

5.3. Case study and analysis

The persons involved in this case were my client, henceforth referred to as Megan, her mother (Heather) and myself (Michael) (all names have been changed, except my own). Consent was given by both Megan and her mother to have our sessions audio-recorded, and for them to be used for research purposes. Sessions took place at a community outpatient facility.

Megan was 19-years-old when she was referred to me for therapy. She had been living in another town (X) with friends, for approximately a year following the completion of her formal school education. One of her friends had noticed her frequent disappearance into the bathroom after meals, and confronted Megan about this. When Megan admitted to binges, and to vomiting after meals, her friends contacted her mother, and Megan was moved back into the family home over 90 kilometres away. Following the advice of a family friend, Megan's mother made appointments for her to see a doctor, a dietician and a clinical psychologist (myself). In our first meeting, I interviewed Heather and Megan together. Heather asked if she could speak with me alone first. Megan agreed to this, and so I

agreed to interview each of them separately before we decided to take the process forward (considering the option of family therapy).

In our meeting, Heather constructed Megan's conduct in a variety of psychological ways, referring to her "insecurity", "denial" of the problematic nature of her conduct, and her behaviour as a sign of "something wrong… with her mind", questioning Megan's "touch with reality". These constructions made possible a variety of governmental practices in relation to Megan, one of which was her referral to health and mental health professionals.

Extract 1

Michael: How did it happen that you ended up coming to see me and Dr Y?
Heather: We were worried, and confused I guess. We didn't know what else to do. I'm worried that we may make things worse if we do the wrong thing, you know?
Michael: Like what?
Heather: We've stopped her from going out with her friends, just to… I don't know… get some control of the whole situation.
Michael: And that may be wrong, is that what you're worried about?
Heather: Maybe, I don't know. Maybe you can guide me about it?

In this manner, Heather constructed Megan's behaviour as a psychological phenomenon about which she had little expert knowledge and know-how. Megan was referred to expert services because psy discourses place problems like bulimia more or less out of reach of the layperson. Heather was "worried and confused", and expressed concern that "we may make things worse if we do the wrong thing". I, on the other hand, was considered an expert in such matters, and a source of guidance. While local (family) knowledge of bulimia as a psychological phenomenon was evident to some extent, the complex, unexpected and confusing nature of its presentation required referral to an expert. This notion of therapist as expert, and the privilege it implies, cannot be separated from the dialogical interactions to be discussed below. Indeed, as discussed in chapters 2 and 3, this is the very position from which I derive legitimacy and become entitled to *practise* therapeutic knowledge in relation to one positioned as client.

Nevertheless, Megan had a different view than her mother. When interviewed later on that same day, the following transaction took place:

Extract 2

Michael: So how do you feel about being here?
Megan: (laughs)… I don't mind. They're all panicking over nothing.
Michael: What? What's the nothing that's worrying them?
Megan: My throwing up and stuff… its not a big problem.
Michael: So what is their fear, what's your mom's fear?
Megan: That I've got a problem… in my head or something.
Michael: And you're saying "not true"?
Megan: Exactly, not true. I just need to lose weight a bit… I know what I'm doing.

Megan refused, initially, to problematize her behaviour in a psychological or therapeutic discourse. This very refusal enabled her mother to evoke a psy discursive construction of a denial of a real psychological problem. For Megan, however, this was a controlled issue of attempts at weight loss, partly as a strategy to attract young men (as emerged later), and not a matter of psychological denial, or a problem with her emotions or mind. Consequently, her parents' efforts to control her did not persuade her that she had a "psychological problem", but rather were seen as overreactions. She stated that she was in control of the situation, while her mother felt she was "in denial". This contest did not effectively challenge or undermine Megan's self-construction, or her mode of knowing and governing herself and her behaviour. Heather was positioned such that her lay knowledge of bulimia was not lent any productive force in Megan's life. While her knowledge may to some extent have been representative of certain "expert" psychological accounts, she lacked the legitimacy – she was not optimally positioned in the psy discursive network's system of power relations - to enable her knowledge to be productive. And regarding Megan, in line with the discussion of chapter 3, she could not be positioned as a knowable, malleable and uncertain other in her relationship with her mother and was therefore not easily persuaded. But in her position as client in a therapeutic interaction, these features could be more easily facilitated.

In sessions, Megan spoke of her eating behaviour as a matter of attractiveness and slimness. I asked: "what convinced you that this is the best way to get what you want?" Megan responded by saying: "I don't know, I just want to lose weight, cos I'm fat, and this is easy, you know? So what?" She refused to construct her behaviour within the psy discourse I was trying to build with her. However, in order to work with such issues in therapy, they must be rendered sufficiently psychological to allow for their psychological elaboration and complexification. That is, it may not be sufficient that her account is individualised: it must be accepting of the psychological complexity that "fills out" the interiority of her individuality. The problem here was this: How can her account be rendered psychologically good-enough to allow our work to proceed? One rhetorical strategy to address this is to focus the dialogue on areas where minimal resistance to psychologization will be encountered, where the stakes (in terms of potential threats to Megan's existing self-self relation) do not appear too high (see e.g., Garfinkel et al., 1985): in other words, to talk about something else. Thus resistance to a psychological discourse is not directly confronted, but may nevertheless be destabilised over time. The contesting of discourses in sessions, and the interpersonal nature of Megan's refusal to have her conduct psychologised thereby become concealed.

Thus, we spoke about Megan's concern that people were generally dishonest. This mattered to her when they said she was thin and attractive. She felt that this was not so much a matter of her own psychology (e.g., her insecurity) as a matter of "real-world" dishonesty (a phrase Megan suggested in sessions) of people around her. In our 3rd session, I gently countered this attribution, posing the question: "Is it hard to trust people when they say nice things?" Megan replied "Yes", which opened up the possibility of reconstructing the perceived lies of others into a matter of her own psychology. It was now not simply that people told lies, but that *she* could not *trust* when they said "nice

things". Talk could then shift from a "real-world" (externally based) discourse to a more internal psychological discourse. This may be seen as a step towards overcoming Megan's resistance against attempts to define her eating conduct in psy terms. Megan and her behaviour – rather than the world around her – thus became our mutual knowledge object: the reality that we had to understand.

The psy discourse was developed further. I suggested to Megan that trust was actually a matter of "risk", and this was built upon by connecting the idea of risk with the idea of bravery and courage.

Extract 3

Michael: I guess it would be very brave really, to trust people… it's quite an achievement really.

Megan: Hmm. Are you just messing with me?

Michael: I honestly feel that to accept a compliment can be a very courageous thing to do. It's risky… you see, I think you have a knack of being able to look at things quite deeply, and so you pick up on all sorts of things that a lot of people just wouldn't be able to even notice… does that sound familiar?

Megan: (pause)… Yes, I think about things like that quite a lot.

Michael: And a lot of people just don't think about things, about things that are more subtle and stuff… and I think you do, and so you could probably tell things like… I don't know…

Megan: Things like… the other day I saw my boss, and he had a funny look on his face, and no-one else noticed… and then I said to Jody, what's wrong with Jay? And she thought there was nothing wrong, and she just said I was paranoid (laughs)… but then I found out that his girlfriend broke up with him…

Michael: And you were sensitive and subtle enough to see that something was up.

My suggestion that Megan could "look at things quite deeply" was offered to her with the question: "does that sound familiar?" This is an example of a "story development question" (Freedman & Combs, 1996), encouraging Megan to develop a narrative of herself as perceptive, "sensitive and subtle". Megan provided an example (noticing her boss's "funny look") through which she could rhetorically develop this discourse. This therapeutically co-constructed knowledge of Megan's sensitivity was then linked back to the discourse of trust as a courageous decision a few minutes later:

Extract 4

Michael: So, I'm wondering, um…

Megan: About it being brave to take compliments and trust people.

Michael: Yes, thank you, yes. It's brave when you're able to pick up on subtle cues, cos you're more likely to see deeply… and so if I say 'Megan, you're great', you could see even unconsciously maybe notice that I moved my head a certain way… and then because you're scared to accept the compliment…

Megan: I'd see that your head movement told me that you were lying…

Michael: Two plus two equals seventeen..
Megan: (laughs) Or three hundred.

In this manner, Megan's initial construction of a dishonest "real world" was systematically worked on, in rhetorical fashion, to the point where her ability to trust was highlighted as the "real" problem. The external world (i.e., lying or manipulative others) was thus *ironised*, or implicitly criticised, as the cause of Megan's uncertainty, while her internal, psychological world (i.e., her difficulty with trust) became *reified*, and rhetorically justified and supported, as the real cause of her lack of confidence in others' honesty (c.f., Billig, 1996; Potter, 1996). Furthermore, trust was then constructed as desirable and brave, reinforcing the location of the problem and its solution within the domain of Megan's self-contained psychology, instead of in the non-self realm of an external, dishonest world. This transformation was constructed dialogically: Megan gave examples and analogies to facilitate this alternative discourse of her experience. Compounding examples and analogies with specific reference to one discourse constitutes a powerful rhetorical justification for the relevance and reification of that discourse. These manoeuvres can be seen as part of Megan's "technologies of the self", working on herself in a particular way, thinking herself as self-contained, and "owning" her fear within the boundary of her self, rather than employing external "real-world" attributions.

In the following session, we returned to the issue of compliments. I asked Megan why I could see the compliments made to her, where she failed to see the compliments inherent in certain actions by others. The example of her being invited out on a date was used:

Extract 5

Michael: What is it that stops you seeing that (compliment) I wonder?
Megan: I suppose its just fear… It's just hard to trust people.
Michael: Fear stops you?
Megan: Yes… just… I get nervous.
Michael: So what does your fear say to you when someone like Lance comes along, and says in his indirect way (by asking her out on a date)… "Megan, you're attractive and I like you"?
Megan: Um, well, my confidence goes low when… when there's that fear.
Michael: So fear says something like: "don't believe him"? Would it be something like that?
Megan: Yes. "He's lying, don't believe him". So it's hard to be brave with that.

Our conversations allowed for the distinction of fear as a force or voice that interfered with her judgement and perception of social situations. Examples of Megan's "bravery" further complemented this account (thereby developing her alternative self-construction): she spoke of the courage involved when she stood up to her father for the first time, prior to our 6th session. Megan saw this as significant, given her father's expectations of her "as a girl"; that she be quiet, unassuming and non-aggressive. Megan described her mother as similarly passive in relation to her husband. She described a sense of pride in "breaking the mould"

with regard to her position in a heretofore unarticulated struggle around gender expectations and power operations. In this way, Megan began to relate certain psy discursive objects (such as courage and fear) to her relationship with her father and his gender-prejudiced expectations and practices. In this way, psychological distinctions can make visible aspects of gender politics (see Swann, 1999; to be discussed below).

Megan's talk of herself and her interactions increasingly involved considerations of her "fear", low "confidence", "trust" and nervousness. By invoking, analysing, developing and complexifying these psy objects and their interrelations, our dialogue permitted the construction of a psy discursive network within which Megan could now (and in contrast to the start of our sessions) account for her eating conduct. And so, in our 7th session, she began to analyse her body image and her eating behaviour in a psy discourse, invoking concepts of fear and courage.

Extract 6

Michael: What attitude would your fear have towards accepting when people say you're attractive... like when Lance asked you out?
Megan: (laughs) I see where you're going you know!
Michael: (laughs) Oh? Where does it look like I'm going?
Megan: That they might not be lying, or that he, maybe does kind of like me that way.
Michael: Sure, they're not. He probably does… How much courage do you need to accept that compliment?
Megan: A lot really. I do sometimes though… take a chance, like be a bit brave.
Michael: Uh… so does your courage… sometimes step in and say 'hey, it's okay, believe it, just this once'?
Megan: Yes, it does sometimes I guess, but not always.
Michael: That must feel great for those short few seconds, when you believe it?
Megan: Ya, before this fear takes over and says like, "ok, that's enough fun for you for one day".

Thus Megan was able to employ the discursive category of "bravery" to accept that some people, sometimes, found her attractive. She decided that her "need to be liked", which she came to believe was fundamental in understanding her eating conduct, was also affected by issues of fear and courage. The following extract is drawn from later on in that session:

Extract 7

Megan: I think, um, I worry that people won't like me, and that I have to be… it's especially when we go out to clubs. The girls there are so like beautiful, some of them.
Michael: Um… if your fear wasn't so dominating, like that, would it be different?
Megan: Well… ya, maybe. Its like my mom says, people have to like you for who you are, as a person.

Michael: So what does courage say, I mean when your fear bluffs you into thinking you're unattractive?
Megan: Maybe… it's there sometimes, I mean I know that's not always true, sometimes I feel sort of, okay… quite good, you know.
Michael: Your fear doesn't always dictate things, do you think? So that courage is coming in there… a bit?
Megan: (pause)… Sometimes my fear isn't that strong… and when it's strong, I want to lose weight and … you know, get rid of my food or whatever. But sometimes that's just a little bit, just to balance it out a little but, I can… this courage comes along, sort of thing… so then I'm okay, and I wouldn't worry too much about that stuff.
Michael: So it brings a bit of an attitude of, like 'I don't care about that'… a little bit of that. So then you worry less, and you don't have to throw up and stuff… the fear is like less powerful and then you just get on with things?
Megan: Just get on with things a bit more, ya.

By our 7th session, as indicated by the above dialogue, and through a relentless subjectifying "therapeutic gaze", in which any of Megan's statements and behaviours could become subject to meaning construction, interpretation and reinterpretation (i.e., via the incitement to discourse immanent in therapy), Megan began to subject *herself* to the intensely applied psy discourse. She could develop a form of self-knowledge – which included her eating behaviour – that was consistent with an individualised, self-contained therapeutic discourse. Thus she began to analyse and construct, in increasingly complex ways, the relationship between her fear, her courage, her need to be liked, her body image and her eating behaviour. Therapeutic questioning had effectively enabled the construction of a network of dynamically interacting psychological objects, contained within and complexifying Megan's "self". Her eating behaviour could then be spoken about as part of this network.

The articulation of these psychological objects and "internal" struggles, in areas *other* than Megan's eating conduct (i.e., where other areas were discussed: e.g., extracts 3, 4, 5, 6 and the first part of extract 7), is ultimately a political and destabilising manoeuvre, eroding Megan's protests against being defined in a certain way. This destabilisation, though I had neither planned nor recognised it in our sessions, is nevertheless an exercise of power; permitted and tolerable because it is concealed, disguised as a therapeutic strategy for the development of self-awareness and problem resolution. It is an exercise of power compounded by the intensity of the focus on Megan's life, behaviour and speech, and by the attendant therapeutic *requirement* that she be – in one way or another – understood: an object of knowledge. Apparently benign, helpful and gentle, talk in therapy is allowed to continue, facilitating the construction of a discursive system (which Megan actively participated in constructing) that eventually, though subtly, undermined her refusal to render a therapeutically good-enough account *of her eating behaviour.* Hence, the concealment of power operations allowed for the dissipation of the initial potential political struggle between us as therapist and client. This struggle involved a contest for the definition of Megan's subjectivity. Megan was conscripted into a self-contained, individualised therapeutic discourse,

becoming empowered to construct herself and her eating behaviour in psychological ways, problematizing her behaviour *as* psychological. In this way, she became recognisable not only to her family and to me, but also to herself, as a bulimic: a person with a decidedly psychological problem with her body image and her bingeing and purging eating behaviour.

With this case, I also emphasise once again that my "therapeutic" rhetorical work cannot be separated from its location: unlike Megan's mother, I enjoy a culturally and historically privileged position as an expert/professional/scientist. As already indicated psychologists and therapists are culturally positioned to tell the truth about human beings (Rose, 1994). But not only do I tell the truth, I am seen as someone trained to be helpful, "therapeutic", someone in whom to confide and place one's trust. To some extent, my position of influence relies on my work and my profession being constructed this way, rather than being exposed as based in power operations that predetermine who should be persuaded by whom, or being revealed as undermining, subjugating or even disqualifying of discourses deemed inconsistent with the therapeutic. With the former highlighted, and the latter concealed, my talk is invested with meaning and significance in a way that Megan's mother's – and Megan's own talk – is not. It is not simply that my rhetorical strategies may have been more persuasive than those of Megan's family, but that my words carry the weight of expertise, knowledge, and thus power.

In our 12th session, Megan announced her decision to return to city X. It seemed that her parents were less concerned about her, and had stopped their monitoring activities. Megan and her mother began to meet for lunches during the week. She described these meetings as pleasant and new for their relationship. She spoke of feeling "strong and positive", and had some clear ideas about her future. She decided to embark on a teaching course, and felt she wanted to work with children. Her vomiting behaviour had significantly decreased. She said she had begun to "forget about it" although she admitted to throwing up "once in a while".

5.4. The possibility of alternative discourses

In order to adequately map out the relations and mechanisms of power involved in the reproduction of discourse, Parker (1992) suggests that research needs to move beyond (while nevertheless remaining grounded in) the study of talk between social participants. It is important to identify institutions, and hence discourses, "which are reinforced when this or that discourse is used"; and identify institutions and discourses "that are attacked or subverted when this or that discourse appears" (p. 18). Without such identification, it becomes hard to consider local talk in its proper power context. We need to consider the ways in which local talk is influenced by, and can be used in turn to support, broader institutional and discursive power relations (Foucault, 1982). These "macro" processes create the conditions under which it becomes possible, and indeed more likely, that local talk will proceed in particular ways. Therefore, with reference to the case outlined above, I consider the possibility of a strategic relationship between the individualised psy discourses, as discussed in relation to

the disciplining of talk with Megan, on the one hand, and feminist discourses on the other.

Feminist discourses are especially apposite here because of the attention given by feminist authors to the subject of eating disorders in particular (e.g., Dolan & Gitzinger, 1994; Fallon, Katzman & Wooley, 1994), and therapeutic practices in general (e.g., Burman, 1998; Crawford, 1998; Heenan, 1996; Kitzinger, 1993). The problem with a feminist-*therapy* arises when we take Duveen (1998) and Burman's (1999) concern that the interfacing of initially divergent discourses (in this case those of an individualised therapy and a more politically focussed feminism – c.f., Kitzinger & Perkins, 1993) is frequently accompanied by important transformations. We must then ask: What may have been obscured by an introduction of (politicised) feminist ideas into therapy? What may have been lost or compromised by the construction of a feminist therapy? Burman (1996) hints at this problem by referring to feminist therapy as a "contested and contradictory project" (p. 3).

It is interesting to note that discursive transformations occurred in the case above, via the incorporation of Megan's self-knowledge by my own psychologised form of knowing. But it can also occur more generally, through the incorporation of feminist discourses into the therapeutic domain. I suggest that this may have resulted in a deradicalised, domesticated and politically neutralised version of feminism. As numerous authors point out, therapy is a problematic way to address female oppression (e.g., Burman, 1998; Crawford, 1998; Heenan, 1996; Kitzinger, 1993). Rather then being highlighted, social and political action risk being understood as optional secondary aspects of individual therapeutic change: self-containment first. Inevitably, psychological and therapeutic discourses highlight individual, psychological processes as a discursive priority, rather than socio-political processes.

However, in a defence of therapy (specifically, narrative-feminist therapy) as a viable strategy for feminism, Swann (1999) takes issue with these critiques, and specifically challenges Kitzinger's (1993) charge that therapy is intrinsically bad for women. Instead, she suggests that it can effectively address the psychological products of women's oppression, while simultaneously pointing towards local political action. According to Swann (1999), "self-blame and unworthiness are examples of the power of oppression operating at a very local level, a level overlooked by Kitzinger's analysis" (p. 111). She (and other feminist therapists) views therapy as one possible means for "politicising the personal". Indeed, this possibility was raised with Megan when she challenged her father, and spoke in sessions of "breaking the mould" by challenging her father's expectations of what "girls" should be like. However, while therapy can make visible such political possibilities, another question is raised: Is the psychologization of disempowerment, involving the construction of discursive objects such as "self-blame", "unworthiness" or "bulimia" (or indeed, "fear", "courage" or "pride", as constructed in dialogues with Megan), necessary to address the problem of female oppression effectively? Do political change and political agency *need* to be mediated by bolstering processes of a psychologised self-containment (e.g., developing a sense of "worthiness", "psychological health", "pride", etc), and by the degree of psychological complexity constructed around these objects in therapy? I argue that they do not. We cannot assume that

therapeutic interventions are the only – or the most appropriate – way of addressing problems of oppression and subjugation.

I question the degree to which psychological complexity, constructed via intense therapeutic self-examination (as evident in the case study) is *required* to render a meaningful account of eating practices labelled as bulimia. But furthermore, therapy might be politically constraining to the extent that it actively conceals the broader gender-political processes that require confrontation. By locating the "cause" (and often, the solutions) of women's problems within a discourse of self-contained psychology, therapeutic practices deflect attention from several issues: (1) from the fact that many more women than men are diagnosed with eating disorders (Hare-Mustin & Maracek, 1997); (2) from the socio-political and cultural processes that render women vulnerable to these difficulties; and (3), ultimately, from the need for social and political action.

I suggest that one of the difficulties facing a non-psychologised feminist discourse is that therapeutic and related individualised discourses have become the predominant way of constructing the person in western culture (Rose, 1998; Burman, Aitken, Alldred, et al, 1996). The have become part of our "common-sense" (Parker, 1999). Thus, unlike feminism, therapy's "individualising tactic" is rendered discursively economical: a minimum of persuasion is required. The individualisation and personalisation of problems comes to seem a "natural", sometimes even necessary way of addressing problems of living. The adoption and psychologization of feminist ideas by therapeutic practices (e.g., via the construction of a feminist-therapy) merely extends therapy's domain of applicability. Thus, working under the influence of these macro discursive strategic outcomes, it becomes relatively unproblematic to persuade Megan of the utility and "truth" of a psychological (as opposed to, for instance, a politicised feminist) discourse in relation to her eating behaviour and herself. In the words of Foucault (1980): "A superb formula: power exercised continuously and for what turns out to be a minimal cost" (p. 155).

But what might a non-psychologised feminist account of Megan's presentation look like? Such a discourse might make possible a rather different dialogue - and would need to take place in an extra-therapeutic setting – leading to different possibilities for self-government and self-regulation. Imagine the following questions are asked within the context of a hypothetical "political empowerment" discussion group. They are offered here as examples of a point of entry into an alternative, de-individualised, and non-psychological discourse:

> Megan, who might be happy/ unhappy should you succeed in becoming really thin? With whom do you compete when you embark on these techniques? For what/ whom are you competing? What is the prize? Who is the judge? Who sets the terms for this competition? Which parts of the community might be pleased by these attempts of yours? Who stands to gain, and who stands to lose? Is it important that women prevent themselves from becoming subject to male values and male-prescribed ideals? To what extent can we say this is the case? What are the benefits/ limits of such subjection? How could you go about preventing your own domination by others? Who would you like to join you? Who would be afraid to join you? What would you do about that? What impact would this have

on your interactions with other women/ men/ children? What values might be more appropriate and useful for you? Who would agree/ disagree with you? What problems might you have the kind of questions I am asking?

It is interesting to note that while some of these questions may appear unusual and even leading (to some), the more interiorising and equally leading questions one would expect of a therapist have come to seem, in the contemporary western world, reflective of some pre-discursive truth about human beings. On this basis, the latter's familiarity and widespread usage may seem to obviate the need for the very last question posed (i.e., "What problems might you have with the kind of questions I am asking?"). And yet individualising therapeutic questions (and comments, interpretations, formulations, etc.) are just as pointed, or discursively biased, although this fact is concealed as knowledge poses as a self-evident quest for truth about the client, which requires no justification other than the generation of "understanding" and perhaps "change". Indeed, this thesis is in large part geared around making this last question relevant to therapeutic practice; to make it possible and necessary to ask what problems there might be both with specific therapeutic questions, and with therapeutic questions in general; to ask what might be suppressed or produced in the application of its theories. For Foucault, this is the proper function of critique: "to show that things are not as self-evident as one believed, to see that what is accepted as self-evident will no longer be accepted as such. Practising criticism is a matter of making facile gestures difficult" (1989, p. 154).

In turn, the possibility of alternatives arises. And in that regard, the questions I propose, while rhetorical and potentially subjugating in themselves, allude to the possibility of constructing Megan's position within a discourse of gender politics, without evoking investigations into psychological matters. This is not a call for the eradication of therapy, and I do not suggest that a feminist discourse is immune from problematic power relations and tactics. As mentioned earlier, power infuses social interactions. However, an approach that highlights rather than conceals power is being promoted. At most, the above questions call for a "naïve" (rather than expert) psychology, and propose talk around interpersonal struggle and political positionings, suggesting a politically located subject whose form of self-government takes on a different aspect. Thus, one's ethics, practices and subjectivities might be informed by different priorities: by the choices made around political situatedness, political agency and how one participates in the world, rather than by a self-contained psychological complexity. This occurs as a consequence of the elaboration of a more politically oriented discourse. As already noted, narrative (e.g., Swann, 1999) and feminist therapies (e.g, Fallon et al, 1994) do address these issues, and the questions above are certainly not precluded from their practice (or anyone else's for that matter). Nevertheless, the issues raised around these questions need not be psychologically complex, and, unlike narrative and feminist therapies, do not necessarily evoke associations with psy discourses, practices or institutions (hence my reference to an imagined "political empowerment discussion group", as opposed to therapy). And yet they are able to make visible an account of bulimia that points us towards "knowing" how to go on.

Thus we are able to locate problems like "bulimia" in a very different discursive domain. Gergen (1999) has indicated that there are currently almost 400 terms for psychological and psychiatric problems, of which bulimia is just one. It is not suggested that all of these might be usefully reconstructed in specifically feminist terms. Rather, I am simply suggesting that all of these problems of living can be constructed in many ways, and that their containment within psy is not always necessary. This encapsulation is further problematized by the suggestion that therapeutic discourse functions to undermine the potentials of alternatives – such as feminism – by claiming and at the same time transforming, psychologising, deradicalising and domesticating them (Burman, 1999). On this account, the psy network's relative hegemony in the definition of "mental health", human distress and its resolution is achieved not through the development and dissemination of objective truth, but through a strategic engagement with other discourses (c.f., Parker, 1992). In the case of bulimia, I have argued that psy conceals alternatives, and risks de-emphasising opportunities for political and social change with regard to gender relations. In short: psy contains and deradicalises alternative discourses via a subjugating circumscription and constitution of the human being as a psychological subject, and its totalising – though often disguised – form of government. Therapists and clients are at the terminus of these processes. I argue that we are positioned as the ultimate destination, and final means of expression, of a power that has been transferred into the therapeutic relationship via a circuitous route: through the neutralisation and (sometimes) incorporation of discursive threats to our ways of knowing and practising, supported by the confluence of our discourses of self-contained individualism with common sense constructions of the person and his or her problems in living.

5.5. Discussion

The therapeutic incitement to discourse, in which both therapist and client are united in their task of understanding the client and his or her behaviour, can be characterised as a therapeutic gaze. It is an "always-looking", always-seeking to understand and discern – in therapeutic terms – the meaning of the client's actions. The client's resistance to this (as evident in the first session with Megan) may be overcome by power, but without confrontation or overt processes of argumentation. As is evident in the case, the client may be persuaded over time to join the therapist in the adoption of this looking and seeking-to-understand stance. Thus, as Foucault (1980) provocatively states:

> There is no need for arms, physical violence, material constraints. Just a gaze. An inspecting gaze, a gaze which each individual under its weight will end up interiorising to the point that he (sic) is his own overseer, each individual thus exercising surveillance over, and against himself (p. 155).

The bulimic subject, defined as a person who becomes subject and subjects herself to the therapeutic and psychologised discourses associated with the category of bulimia, is a product of such a gaze, and cannot exist without the discourses that qualify and direct it. These discourses construct her as an object

of knowledge, and so in their interiorization, produce a bulimic subjectivity. I have tried to illustrate how, during the course of therapy, Megan began to construct herself within these discourses. Her behaviours were discursively linked to psychological objects such as "fear", "courage", "the need to be liked" and "body image". These distinctions construct a psychologically dynamic complex designed to move Megan towards the possibility of becoming "psychologically healthy" (precluded from a psychological account of bulimia), insightful (acknowledging and working on the problematic nature of her behaviour), accurate in her judgement of appraisals of social situations (such as when people like her), and accurate in her appraisals of her body image. The inevitable assumption is that her "problems" initially reflected otherwise.

It is important to note that Megan displayed some initial resistance to this discursive positioning of herself. However, the introduction and elaboration of a psychological discourse prevented this resistance from developing into an alternative account of her conduct. Thus, the possibility of an alternative account was suppressed, and the means of suppression concealed. In the process, therapeutic discourse is also rescued from critique.

This suppression and concealment are important for therapy, since its success relies on the ability of clients to construct themselves as psychological beings and to act accordingly (Parker, 1998). When resistance to psychologization is encountered, rhetorical strategies and operations of power may be employed to discursively resituate these protests in a psychological discourse. While facilitating therapy, these manoeuvres deradicalise resistance, reducing its potentials to expose and effectively challenge the psy discourse and the mechanisms of power through which it becomes productive. Specifically, the rhetorical, argument-based, even governmental nature of our work is hidden from view by the psychologization of resistance. Instead, a view of therapy as the benign, good-natured practices of a helping profession is made possible.

The revelation of resistance as a political rather than psychological manoeuvre marks one possible beginning of the "insurrection of subjugated knowledges" (Foucault, 1980, p. 81). Subjugated knowledges include both "local popular knowledges" (such as Megan's account of herself) and more erudite and specialised knowledges (such as feminism). Thus, as highlighted throughout this work, a critical look at operations of power in therapy might begin by exposing power, thereby permitting the invocation of previously subjugated and disqualified "naïve… local popular knowledges" (Foucault, 1980, p. 82). These knowledges can form the beginnings of protest against an unwanted discourse. In this vein, Falzon (1998) has interpreted Foucault's work as embodying a "dialogical ethics, i.e., the ethical as an attitude of openness to or respect for the other, for *that which resists*" (p. 64, emphasis added). From this perspective, the discursive transformation of protest into psychological resistance does not conform to a "dialogical ethics".

How might such insurrection and a respect for "that which resists" be achieved in therapy? Certain therapies (such as narrative therapy – see chapter 8) have attempted to address the problem of subjugation and hidden power mechanisms by exploring strategies of power, discursive positioning (White & Epston, 1990) and the problems of gender oppression in the therapeutic relationship (e.g., Morss & Nichterlein, 1999; Swann, 1999). In my own practice,

the tension that has arisen between my dual roles of therapist and critic/analyst has led to an emerging respect for resistance as protest, and the facilitation of client accounts that might otherwise be subverted by a psychologised discourse. Specifically, it has been helpful to prioritise for attention hints of new stories expressed by clients, which might sometimes be inconsistent with psychological or self-containment discourses. In their articulation and development, these alternative discourses can promote a different set of subject positions and power relationships within the therapy setting itself.

This is not simply replacing one story for another. The insurrection of a client's account is not intended as a means for structuring intervention in therapy (which might suggest at its extreme, for example, that a suicidal bulimic should be left to die), but involves employing resistance as a point of reference against which subjugating practices might be analysed and highlighted. And so, following Byrne and McCarthy (1999), psychological or therapeutic discourses need not be rejected in therapy, but can be relativised in their discursive juxtaposition with other discourses – in this case, an emergent discourse of resistance. This means that a psy discourse might be used but also questioned, in the therapist-client dialogue, by invoking and elaborating local, specific discourses of resistance as they emerge in sessions, and vice versa. In this way, resistance can be retained and to some degree respected as a political rather than psychological performance. Power and subjugation are not removed in the process. However it is suggested that an acknowledgement of the political, rather than psychological, nature of resistance can enable a relationship in which psychological discourse and its territorializing potentials are problematized and critiqued in the therapist-client dialogue itself.

However, despite these attempts to address power in the therapist-client relationship more openly, tensions remain. First, as a psychologist myself, I question the extent to which a psychological discourse is required at all to address such issues effectively (at least in the case of bulimia). For example, in considering the practice of juxtaposing discourses referred to above, and the narrative therapy work exemplified by Swann (1999), I question the apparent necessity of psychology discourse's retention – albeit in problematized form – as the primary discourse around which a discourse of resistance should be articulated. Certainly, therapists' training and proficiency in using such discourse, coupled with their widespread cultural availability and utilisation, facilitate their retention as a discursively constructive force in formalised helping relationships. And yet, while therapy practices require individualised, psychologised clients, the construction of a discourse for problem-resolution does not. There are many non-individualised, relational, political alternative discourses that could make visible new practices, power relations and subjectivities in relation to those positioned as clients. In this regard, the example of a non-psychologised, perhaps even non-therapeutic, feminist discourse has been suggested as a means for reconstituting problems such as eating disorders.

There is a second problem, however. Using alternatives, such as a feminist discourse, in a therapy setting does little to challenge the therapeutic and broader family of psy institutions themselves. While the use of feminist accounts within therapy might highlight power and subvert psychologised discourses at a local level (in the therapist-client relationship), such a practice reproduces the cultural

prescription that problems like bulimia fall into the therapeutic domain, requiring the expertise of its practitioners, regardless of the discourses used within that setting. Feminist-therapy might not challenge this so much as reinforce it. Indeed, certain authors argue that feminist therapy is an advertisement for therapy rather than feminism. According to Crawford (1988), feminist therapists tend to reference their feminism "only covertly and euphemistically": "a therapist who reveals her feminism will lose business" (p 82).

And so problems of living are retained as the territory of mental health professionals – in all their guises – even if the latter de-privilege and problematize languages of individualism and self-containment in dialogue with clients. Thus, the local, in-session questioning and analysis of knowledge and power become, in themselves, questionable political strategies. Our work is still called "therapy" and we continue to practice within a broader network of power relations, in which we continue to be positioned *as* therapists, thus positioned very differently than our clients can be. But more than this, with regard to "knowing" about human beings, western culture has situated therapeutic and related practitioners in a privileged position relative to practitioners (authors, speakers, researchers) of other erudite discourses. Whatever we do within therapy, our work threatens to leave the subjugation of other discourses relatively unchallenged, thereby reinforcing the hegemony of the network of disciplines, knowledges and practices associated with psy.

And so, in addition to reflecting critically on our work by analysing the subjugation of local (common-sense) knowledges of our clients in day-to-day work, we should also confront the subversion of alternative (erudite, disciplined) discourses. For example, psy discourses have been able to resituate feminist concerns within therapeutic and related discourses. This appropriation threatens to undermine the political potentials of feminism through the psychologization and individualisation of gender relations and personhood. However, a non-psychologised feminism might point to different power networks and subjectivities than might a feminist-*therapy*. Specifically, it has been suggested that a feminist account could encourage political agency as a discursive priority, without therapeutic discourse's requirement that such agency be mediated by its psychologization. A feminist discourse does not require such discursive relocation and transformation in order to make visible an account of "how to go on" in relation to what has been called bulimia. But it also goes further than this, to highlight and strategise over problems of power, inequality and gender oppression at a broader socio-cultural level; a task which I submit therapeutic discourses obscure from view, and yet it is one that we are not adequately equipped to undertake under the guidance of our therapeutic discursive frameworks.

In an attempt to resist the subversion of other discourses, we might engage in dialogue with other practitioners of other knowledges, and together consider how networks of power and subjectivities might be formed in new ways. Through such dialogue, we (psychologists, psychiatrists, psychoanalysts and therapists) should be challenged, and continually ask ourselves, when we borrow concepts from feminism, anthropology, history, sociology, political science, or any other form of erudite knowing, the question: What is it that we are failing to understand, or obscure from view, when we appropriate other discourses? What transformations are effected by this appropriation? These are also the questions

that should be asked of our engagements with clients' accounts. Further, dialogue focussing on which discourses might potentially be employed in which settings, and in relation to which problems, might promote the visibility of discourses that prevent discursive closure and the de-radicalisation of resistance. Such negotiation might allow for, or even require, the construction of new discourses, power relations and subject positions. By investigating these issues – both in our sessions, and in our reflections on our position within broader networks of discourse – we might begin to acquire some insight into what opportunities for political agency we miss, as well as become able to locate or construct discourses through which such agency can be enhanced. Importantly, this could conceivably lead to a de-territorialisation of certain problems of living, which need not necessarily be accounted for in psychologised or self-contained terms, rendering referral to psy-practitioners just one possible option amongst many. In this way, we might usefully undermine psy hegemony as we explore discursive means by which psy discourses can be prevented from effecting an ever greater encompassment and subjugation of the human being.

5.6. References

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CHAPTER SIX
THE POSSIBILITY OF THERAPEUTIC "NON-POWER": THE CASE OF DIALOGICAL THERAPY[6]

6.1. Introduction

The preceding chapters have addressed certain complexities of the relationship between knowledge, power and resistance in the therapeutic relationship. Therapy has been reconstructed as a rhetorical endeavour, intensified by an incitement to discourse, through which the client becomes persuaded to construct him- or herself as an object of knowledge in the first place, and secondly, in terms of some variety of therapeutic discourse, typically itself framed in self-contained terms. But more than this, it has been argued that therapy and its practices are only made possible and effective (or productive) to the extent that alternative discourses, which threaten to undermine and problematize therapy, are silenced, marginalized, transformed or rendered impotent in their shaping of human conduct. The therapist's local exercise of power should be seen in this context. But in this chapter, I will specifically address the claim that therapy can be exorcised of power through a de-privileging of the knowledge practices with which it is usually associated.

Collaborative language systems therapists Harlene Anderson and Harold Goolishian have developed an avowedly postmodern, social constructionist approach to therapy, that focuses on the role of language, both in the generation and resolution (or "dissolution") of personal difficulties (Anderson, 1997, 2001; Anderson & Goolishian, 1988, 1990; see also Andersen, 1987; Hoffman, 1992; Penn & Frankfurt, 1994; Seikkula, 2002). Their work has been a source of inspiration to many therapists seeking to move beyond the perceived limits of expert, knowing discourses (e.g., Hoffman, 1992). It has been developed and researched by numerous others (e.g., Gehart-Brooks & Lyle, 1999; Kamya & Trimble, 2002; Roberts, 1998), and is theoretically congruent with Andersen's work with "Reflecting Teams" (e.g., 1987), and Seikkula's "Open Dialogue" approach with the families of psychotic individuals (e.g., 2002). I shall refer to this grouping of approaches as "dialogical therapies", in that they share two defining features: (1) a focus on dialogical processes within therapy; and (2) the construction of a distinction between dialogue and monologue.

It should be noted at this point that these "dialogical therapies" are distinct from the "dialogical-*self* therapies" discussed in chapter 3. Although there is some overlap between these approaches – for instance in philosophical background, the attempt at egalitarianism, and the recognition of the fluidity of personhood - Anderson and Goolishian's work prioritises the interpersonal dimensions of dialogue; while Hermans' and others in the dialogical self movement emphasise the personal, "within-self" aspects of dialogue.

This chapter examines the interface between power, on the one hand, and "not-knowing" (as opposed to subjectifying knowing) practices, constructed in terms of the principles of dialogue versus monologue, on the other. It will be

[6] Chapter based on: Guilfoyle, M. (2003). Dialogue and power: A critical analysis of power in dialogical therapy. *Family Process, 42* (3), 331-343.

argued that in dialogical therapy, power tends to be conflated with hierarchy, control and domination. In these terms, Anderson and Goolishian consider power to be an unnecessary – and removable - impediment to dialogue. This chapter attempts to explore (1) whether the removal of power is *necessary* for dialogue to occur, and (2) whether such removal can ever be successful. Conversational data and a case study - from Anderson (1997) – are used to explore these questions empirically.

6.2. Conceptual issues

6.2.1. Dialogical therapy: basic principles

The dialogical therapies construct a distinction between monological and dialogical discursive practices, and it is on the basis of this distinction that a view of power is constructed. In this section, I attend to the monologue/dialogue distinction, before exploring the principles and practices of therapeutic dialogue, in terms of the view of power being developed in this thesis.

Monologue is characterised by an addressor's failure to adopt the role of *addressee*. This means that the speaker is neither shaped nor moved by the voices with which she or he interacts, thereby creating for him or herself a position of authority (Bakhtin, cited in Morris, 1994). Monologic discourses, because of their production in, and reproduction of, authoritative positions and practices, tend to be exclusive (rather than inclusive) in their authorship, and exclusionary in their consequences. The monologic refusal to shift in response to another's utterances may also be associated with imposition on the other. For dialogical practitioners, approaches that view therapists as experts in the content areas of people's lives predispose towards monologic rather than dialogic relations. Instead of new meanings being collaboratively generated in conversation with clients, meanings already inherent in the therapist's store of expert knowledge are (re)produced. Thus, influence is unidirectional: while the client is influenced by the therapist, the therapist remains entrenched in an already established and articulated system of knowledge.

Dialogue, on the other hand, invites participants to both influence and be influenced, to shape and be shaped by the interaction, and to be mutually involved in meaning construction. It is thus characterised by an egalitarian rather than authoritative stance. An effective distinction emerges: monological conversations inhibit the generation of new meanings, while dialogical conversations facilitate the production of new ideas and, hence, change (Anderson, 1997; Kamya & Trimble, 2002; Seikkula, 2002). Thus, a conversation is deemed therapeutic to the extent that it shows dialogical – rather than monological – properties. Dialogical therapy works precisely through the performance of dialogue, and does not require accompanying theoretical accounts of personality or problem causation. Instead of reproducing already determined (e.g., theoretical) meanings, dialogue permits the generation of *not-yet* said or heard meanings. And so, to engage in dialogue, a therapist adopts certain attitudes and practices. In this regard, I will address three concepts: not-knowing; joint action; and the unfinalizability of meaning. While these are not the

only important concepts in dialogical therapy, I use them here to construct a skeletal impression of how dialogue is made practicable.

The adoption of a "not-knowing" stance facilitates the collaborative emergence of new ideas (Anderson & Goolishian, 1988). It is here that we begin to see a challenge to the link between power and knowledge posed by Foucault and explicated throughout this work. Not-knowing means that the therapist suspends theoretically derived knowledge, and maintains a critical awareness of any preconceptions that might seep into the therapeutic encounter. The client's narrative, rather than the therapist's knowledge, leads the way (Anderson, 2001; Seikkula, 2002). It should be noted that not-knowing does not mean that the therapist cannot offer his or her ideas. It means rather that they should be offered tentatively, as something the client is free to consider or discharge, thereby maximizing the "egalitarian and mutual search for meaning" (Anderson, 1997, p. 137).

Anderson (1997) uses Shotter's (1993) term, "joint action", to emphasize the mutuality of therapeutic talk. That is, new meanings are seen as interactively – or dialogically – produced: emerging not from the intentions of individual speakers, but *between* speakers, from within the conversation itself. Thus, a new narrative is a joint production: "The conversation, not the therapist, is its author" (Hoffman, 1992, p. 18). If meaning originates between speakers, and dialogue is by definition constantly in flux, then meaning cannot be fixed: it is always "unfinalizable" (Bakhtin, 1981). When fixedness *does* occur – e.g., through authoritarian impositions of meaning - we can be said to have entered the realm of monologue. Dialogical therapy aims to dissolve such fixed meanings, utilizing the natural "slipperiness" (or unfinalizability) of meaning as a resource for the development of new, as yet unheard or unsaid, meanings.

What implications does power have for this view of dialogue? It should be reiterated that the concept of power predisposes to critical analyses. Therefore, I follow Rose's (2001) suggestion that attempts to help people in distress should be analysed with care and respect. The following critique, as with all the chapters presented here, is not intended to be destructive, but rather aims to highlight issues that current constructions of dialogue obscure from view.

6.2.2. Dialogical therapy and power

Dialogical therapists tend to associate power with processes of authority, domination, control and hierarchy (e.g., Anderson & Goolishian, 1990; Hoffman, 1988, 1992; Owen, 1992). This conflation of concepts invites an identification of power with monologue, and constructs the removal of power from therapy as an ethical imperative: not-knowing is seen to precisely serve this purpose. Anderson and Goolishian (1990) argue that power in therapy stems from the use of "expert" language, and its imposition on the client's experience. Seeing this as "unacceptable", they propose that not-knowing and the prioritization of dialogical *process* (rather than content) render control and power "nonproblems" (1990, p. 161). According to Hoffman (1992), therapists are "professionals disguised as experts"; but not-knowing and the dialogical focus help to make "the expert disappear" (p. 17). Thus, Anderson and Goolishian (1990) state:

> We … reject the concept that therapy is the exercise of power and control in a beneficent fashion. We also reject the position that power and control are essential concepts either to the understanding or the practice of the therapeutic process. Still further, we reject the assumption that control and direction are necessary for the therapist to behave in a responsible clinical manner (p. 160).

More recently, Anderson (2001) stated that therapists "have culturally and theoretically deemed power and authority", which are often "wittingly and unwittingly, misused" (p. 351). Nevertheless, she maintains that therapists can choose whether or not to use this power. Power is again not regarded as essential in understanding or practicing therapy, and its potential influence deemed removable through the therapist's adoption of an egalitarian, not-knowing and collaborative stance.

This position embodies two important assumptions. First, power is considered an obstruction to dialogue, constraining a client's expression of what is yet to be said or heard. Second, it is considered *possible* to systematically exclude power from the therapist-client interaction. I aim to demonstrate firstly, that both of these assumptions are problematic, and, secondly, that in the attempted separation of power from dialogue, therapists do not remove power, but instead conceal its visibility.

6.2.2.1. The question of obstructing dialogue

Is power an obstruction to dialogue? To address this question, I will again invoke aspects of Foucault's writings. As noted in chapter 1, power may be defined as "a total structure of actions brought to bear upon possible actions: it incites, it induces, it seduces, it makes easier or more difficult" (Foucault, 1982, p. 220). But acting upon the actions of another – positively shaping his or her conduct – does not necessarily imply domination. The key to understanding the power/domination distinction is resistance. Resistance, as has been repeatedly noted, is not necessarily an internal, psychological process, but one end of a local power relation (e.g., between therapist and client), in which power moves to transform the actions or subjectivity of one party, while the latter resists such transformation. In power relations, the ever-present possibility of resistance makes interactions dynamic and reversible, comprising a "dialogue of forces" (Falzon, 1998, p. 43). On the other hand, domination precludes the possibility of resistance impacting on proceedings, and so the relationship becomes one of an authoritarian (monologic) imposition of meaning.

Foucault maintains that power (together with resistance) infuses the social arena, which is seen as a network of strategic relations, in which our ordinary, everyday, professional or non-professional practices function, though often unwittingly, to reinforce, undermine, or transform socially available discourses (Foucault, 1980; Torfing, 1999). Thus, as White and Epston (1990) argue, we are at all times strategically positioned in discourse, and inadvertently, but inevitably, contribute to "macro" dialogues between discourses.

These points - the power/domination distinction and power's immanence in social interaction - have more than semantic significance. They enable a more socially inclusive concept of dialogue, applicable not only to special interactions – such as dialogical therapy – but to everyday interactions, which are not always characterised by egalitarian intentions, but also by "discrepancy, opposition, negotiation and conflict" (Valsiner & van der Veer, 2000, p. 389). The egalitarian requirement places dialogue beyond the reach of most spontaneous social interactions. If "genuine dialogue" requires the expression of distinct views (Sampson, 1993, p. 143), then we must consider that each perspective may not always be equally heard or equally shaping of the conversation. Dialogic joint action does not ensure, for all participants, equal participation in or satisfaction with dialogue's processes and outcomes. This inequality hints not at domination, but at power. Thus, mutual construction (and hence, dialogue) is not to be confused with an absence of power. As shown in chapter 4, talk can be analysed in terms of dialogical, joint processes, while still retaining a view of rhetorical or persuasive techniques that constitute exercises of power.

The inter-relatedness of dialogue and power has been recognized by many theorists of dialogue (e.g., Falzon, 1998; Hermans, 2001; Sampson, 1993), and is implicit in Billig's (1996) work on rhetoric. To reiterate, Billig argues that thinking and talking involve processes of argumentation: as one position is justified, another is explicitly or implicitly criticized. In the process, new attitudes, beliefs and ideas may be constructed. Argumentation, in Billig's rhetorical sense, is not seen as ethically problematic, or as involving processes of domination, but as the prototypical manner of being in conversation. In other words, Billig's account suggests that the creation of new meanings does not require the idealized versions of dialogue emphasized in dialogical therapy, but the presentation of *distinct* views, which introduces the possibility of conflict, persuasion and other tactics of negotiation: exercises of power (Falzon, 1998). Anderson and Goolishian (1990) argue that such rhetoric is not a feature of therapeutic dialogue, although it seems commonplace in ordinary, everyday conversation (Billig, 1996).

Consider, for example, the following (fictitious) interaction:

Extract 1

1 Joe: Mark, lets go for a drink tonight.
2 Mark: No thanks Joe, I just want to stay home tonight.
3 Joe: Come on! You know that you'll enjoy it. You're so lazy man!
4 Mark: Joe come on, that's not fair. Besides, you also get lazy
5 sometimes! Look, I'd prefer to go out on the weekend. I
6 won't be lazy then. I just need tonight at home, okay?
7 Joe: Okay, okay. So its Friday night okay? Can I tell the others
8 to meet us there?
9 Mark: Yeah, that's what I'd like. Friday night, cool, sounds good.

Here, the features of dialogue are easily marked. Distinct views are presented; they are talked (i.e., argued) through; and through a partial "synthesis" of voices (one way in which dialogues produce new meanings – see Valsiner, 2002), a new idea emerges: Mark will go out on the weekend. The issue of power appears when we consider how the discourses invoked position the two

speakers. I will attend only briefly to these, demonstrating how they construct power relations consistent with dialogical rather than monological processes.

Joe invokes a discourse of laziness around Mark's intention to stay in (line 3), which problematizes Marks' position, and normalizes Joe's wish to go out. Here, power involves actions designed to produce, or invite, certain kinds of re-action (e.g., to persuade Mark to go out). However, Mark does not passively accept Joe's construction. He accuses Joe of being unfair, and of being lazy himself (lines 4-5), and thereby constructs for himself a speaking position which enables him to criticize Joe's position, and justify his own. This is resistance. He refuses to have his actions shaped by the discourse that Joe brings into play. In the end, Mark succeeds in staying in, and Joe is persuaded to alter his stance (lines 7-8). And although Mark agrees to go out, he now does so apparently on his terms: "that's what I'd like" (see lines 5-9). It is not precisely clear at this point who is influencing whom, whereas at the beginning of the extract, a directionality of influence was evident. Thus, there is a subtle shift in the power relation. This indicates that monologue – the imposition of meaning without hearing the other - is avoided, and the interaction is rendered dialogical.

This example demonstrates how power relations can infuse dialogue, *without compromising the dialogical status of the interaction:* power and resistance work together to produce a dialogical interplay of forces (Falzon, 1998). Dialogue, in other words, does not require the removal of power operations or rhetoric. It does, however, require resistance to the exercise of power, which may be (but is sometimes not) expanded into a form of counter-rhetoric (c.f., Foucault, 1997). The therapeutic dissociation of power from dialogue only problematizes this kind of ordinary dialogical interaction. A question therefore arises: Is there a difference between this kind of conversation, in which shifting power relations are evident, and a "dialogical" therapeutic conversation supposedly devoid of power? In other words, why must conversational operations of power be excluded for *therapeutic* conversations to be considered dialogical, and yet be exercised in the dialogical encounter described above? To more fully address that question, we need to turn to the second assumption about power.

6.2.2.2. Power within boundaries

The assumption that power can be kept out of the consulting room amounts to a decontextualization of power. Following Foucault (1977, 1980) again, power transcends the intentions of local social participants (a point made also by Hare-Mustin, 1994; and White & Epston, 1990). There are at least two problems with the focus on intentions as the chief determinant of the exercise of power (e.g., Anderson, 2001). Firstly, it is *action* (including speech) and not intention that shapes the actions of another: power involves action upon action. But more than this, an individual's actions cannot be considered *autonomous* exercises of power: local actions are merely power's "ultimate destinations… where it becomes capillary" (Foucault, 1980, p. 96).

On this issue, recall Foucault's reference to power as "a *total structure* of actions…" (1982, p. 220; emphasis added): power here is always an *ensemble or organisation* of actions, in which the individual actor is simultaneously its effect (i.e., being constructed through discourse in one or other subject position) and its

vehicle (or, the conduit for its actualisation and expression). This total structure of actions is informed by a variety of actions: (1) how people choose – with intention - to position themselves in discourse; (2) how people *are positioned* – regardless of intent – by others (clients, the lay community, the mental health professional community) in discourse; (3) the positioning of discourses in relation to other discourses and institutions (an issue considered in chapters 3, 4, 7 and 8 – see also, Parker, 1992, 2002); and (4) knowledge forms that "discipline" discursive practices (e.g., the shaping of therapeutic talk by theoretical knowledge). All of these factors, and perhaps others, impact on the local actions of social participants: all play a role in the performance of power relations.

On the other hand, the collaborative therapists' treatment of power as related to personal intent acknowledges only the power inherent in locally and deliberately invoked discourses. While attention is given to therapy's socially situated nature (e.g., Anderson, 1997, 2001), there is nevertheless a failure to acknowledge the ways in which speakers *are positioned* in discourse (as opposed to choosing a position), by clients and within the broader social context. Power is made available to different people on the basis of their positioning within discourses that are *culturally and socially* – not individually – and strategically constructed, and which serve as a context for local practices. For example, medical discourses position doctors with more speaking entitlements, decision-making powers and liaison links than their patients, regardless of the doctors' intentions. Thus, people are positioned so that they do not necessarily claim, but nevertheless inherit "category entitlements" (Edwards & Potter, 1992) not afforded to others. If intentions do not exhaust the multiple ways in which power operates, then power is not something a therapist can simply choose to avoid. Rather, it is already there, within the relationship, a product of the institutional and contextual forces that position persons categorized as therapists differently than persons categorized as clients (Hare-Mustin, 1994).

I will now turn to an extract from a therapy case to more closely explore power within dialogical therapeutic practice.

6.3. Case analysis

The case extract to be examined (from Anderson, 1997) has been selected because it depicts the therapist introducing an idea into the conversation. This would be the point at which we might ordinarily notice the shaping effects of knowledge and rhetoric. And yet the dialogical therapeutic view proposes that there are ways of introducing ideas that shed knowledge of its privileged status, and thereby remove any element of power and persuasion from the interaction. Of interest here, then, is the question: How is the idea introduced, and what therapist actions prevent this idea from dominating the interaction (or unduly shaping the interaction or the talk)? In the extract, collaborative language systems therapist Harlene Anderson talks with a client, Natalie, about her difficulties with her daughter. Natalie is concerned that her daughter may move in with her father, from whom Natalie is divorced. Anderson functions here as a consultant to Natalie and Sue (Natalie's therapist).

Extract 2

Harlene: I guess what I'm thinking is that, at least where my mind is right now, is that it's not like a question of 'Is she with you or is she with her dad'. Although to me that's an important question, important issue, it seems like the most burning issue is, 'Is there any way, is there any hope, is there any chance that the two of you can salvage something in your relationship and have more the kind of relationship that I would imagine both of you would like to have?'… So I guess that's what I'm thinking.
Natalie: That's more the question rather than where she lives …
Harlene: Well that's what I'm wondering… if that's what really, I mean it sounds like you would desperately like to have a relationship with your daughter, you would like for that to go smoother, and of course you punctuate that with 'good mother/bad mother' which I think most mothers probably do, so I don't think that's that unusual. So that's what I'm wondering, I mean, what do you think it would take for you and your daughter to be able to talk about anything or try to…
Natalie: Well, what I want… I don't …
Harlene: see anything there to capture or repair.
Natalie: Well, what I'm thinking is what will make it impossible is if I just send her off angry, you know, like 'well just go ahead and go and don't call me' and all that and, you know, well that could mean, I mean, I …
Harlene: Well, it's also your biggest fear, that she's going to go there and everything will be hunky dory and that that will really close the door, and maybe when she's thirty-five, she'll come back, but I don't know, it sounds like you're … that that's what you're grasping for.
Natalie: That I'll have a normal relationship with her, yeah.
Harlene: Maybe I'm totally wrong, but …
Natalie: Yeah, that's probably…
Harlene: Well, I don't know.

(Anderson, 1997, p. 186)

Here Anderson embeds her expressed idea – about what she considers the "most burning issue" (line 13) – in a performance of not-knowing. She employs what may be termed discursive uncertainty markers, which remove the authority of her voice, replacing it with a voice that is not-knowing: uncertain rather than certain, personalized rather than objective, and relative rather than universal. Thus we see the following statements which show her input to be derived from not-knowing: "I guess what I'm thinking is that, at least where my mind is right now" (lines 10-11); " to me" (line 12); "it seems like" (line 13); "I would imagine" (line 16); "So I guess that's what I'm thinking" (line 17); "but I don't know" (line 36); "Maybe I'm totally wrong" (line 39); and "Well, I don't know" (line 41).

The rhetorical functions of these markers can be highlighted by re-examining a sample of the interaction (from lines 10-17), but now with the verbal

uncertainty markers removed. In their absence, Anderson's initial statement would read as follows:

Extract 3

Therapist: It's not like a question of 'Is she with you or is she with her dad'. Although that's an important question, important issue, the most burning issue is, 'Is there any way, is there any hope, is there any chance that the two of you can salvage something in your relationship and have more the kind of relationship that both of you would like to have?'

In this extract, the uncertainty of excerpt 2 is removed, and it is more difficult to see where not-knowing is communicated. The therapist assumes the role of sole-author, and defines, rather than tentatively suggests, the most important question for the client to consider. This utterance does not easily lend itself to the mutual production of priorities (regarding which question to address). Indeed, little room is made for the client to disagree or propose new meanings. Rather, extract 3 approaches an authoritative, rather than egalitarian, statement of an expert therapist, devoid of accompanying comments that mark her definition as debatable. The therapist's imposition of priorities thereby risks hindering "dialogical exchange by prematurely fixing… the range of discourse, and by leading to early closure of the client's story" (Anderson, 1997, p. 135). On the other hand, discursive uncertainty markers (in extract 2) effectively relativise and de-authorize the therapist's statements, invite client collaboration, and permit the *joint* production of meanings: "a collaboration in which no one has the final word" (Hoffman, 1992).

Certainly, these uncertainty markers do not in themselves constitute not-knowing. Not-knowing involves numerous other discursive processes, such as conversational questions, non-intrusive curiosity, and speaking from within the conversation (Anderson, 1997). However, it seems that uncertainty markers serve an important rhetorical function when the therapist introduces new ideas to the conversation: in their absence, therapist input appears "expert", and cannot be characterised as a *communicated performance* of "not-knowing". The integrity of a not-knowing position is thereby undermined, and we move closer to monologue (e.g., extract 3). The presence of these markers, however, is integral to not-knowing. They become a means by which therapists attempt to *simultaneously* participate in, and remove power from, therapeutic dialogue. But do they succeed?

6.4. Power and the need for special discursive arrangements

The presence of power in extract 2 is indeed difficult to detect in the interaction cited. It can of course be argued that the therapist's introduction of an idea has a special impact on the client because of her status as a knowledgeable expert (despite Anderson's claims to the contrary), and via an incitement to discourse that focuses exclusively on the life of the client. These points have already been extensively argued in previous chapters (see also Atkinson, 1993; Golann, 1998; Young et al, 1997). But there is another way in which power may be revealed in

this case, and that is via a comparison with extract 1. There is one clear difference between these interactions: while uncertainty markers in the therapy extract de-authorize expertise and invite client collaboration, such markers are distinctly absent from extract 1. Joe does not qualify his accusation ("you're so lazy" – line 3) with comments such as "but that's just my opinion", or "I could be wrong about that". And yet the conversation remained dialogical. Mark's *resistance* to Joe's forthright ("knowing") assertion sustained the dialogue. He acted into the conversation in a way that supported its dialogical status (i.e., by undermining the certainty of Joe's statements). Significantly, Joe did not have to do this *for* Mark in order to be in dialogue.

The therapist in extract 2, however, works *for* the client. She does not simply leave the client to challenge or undermine the former's statements. The therapist seems to recognize that – unlike in extract 1 - she *cannot do so* if the interaction is to remain dialogical. Rather, she actively elicits client participation, and client "voice", through the performance of uncertainty and not-knowing, without which her utterances risk appearing monological, and constraining of the client's responsive potentials (i.e., more like extract 3). And so, the therapist communicates her ideas with uncertainty, and makes transparent her non-investment in the content of her comments. In a sense, she *removes* – rather than adds - the distinctiveness of her voice, recognizing that her knowing voice might have too much persuasive and shaping power.

The difference between extracts 1 and 2 problematizes Anderson and Goolishian's (1988) statement that the "therapeutic conversation is basically no different from any other" (p. 382). It seems, rather, that therapeutic conversations are significantly different from many other spontaneous conversations: within therapy, special discursive arrangements are required for dialogue to be sustained. Power may well compromise dialogue in therapy, but as noted with respect to extract 1, it does not necessarily compromise dialogue *per se*. What does this tell us about power in dialogical therapy?

6.5. Dialogical therapy in the context of power

Dialogical therapies seem to require special speaking arrangements and techniques as a condition for dialogicity. In the absence of these conditions, the conversation does not move towards the dynamic and fluid relation exemplified by Joe and Mark (in which meaning remains "slippery") but towards the authoritative, expert and monologic interaction alluded to by extract 3 (in which meaning becomes more fixed). Therapy emerges as a special speaking situation, in which the requirement that prescribed, predetermined speaking conditions are met (therapist uncertainty, not-knowing and the partial removal of voice), points not to the absence of power, but to a *pervasive* power relation, which has to be countered at all times. The therapist has not only to remove undue persuasion from his or her voice, this removal has to be constantly demonstrated to the client. Uncertainty has to be continuously communicated. There is an implicit assumption that – unlike in extract 1 – without verbal indicators of not-knowing and uncertainty, the client might "hear", not simply another voice (such as that of a friend), but expertise and authority. Indeed, Young et al (1997) have argued, on the basis of their research, that in collaborative therapy, clients may still – as

therapy ends – perceive, and thus hear, the therapist as expert. Power has to be systematically and continually warded off, precisely because it is already there – influencing how the therapist's comments are heard - and cannot be completely expelled.

This point is significant. If power – as a total structure of actions – is already structured into the therapeutic situation before therapy even begins, then this power is something that not-knowing and knowing therapies have in common. Despite conceptual differences, dialogical therapy shares with other (knowing) therapies its status as an instance, an example, of a broader therapeutic institution. It inherits the same forms of power and *in that respect* may be no different from other forms of therapy.

And so, to answer the question "where is power in dialogical therapy?", I suggest that it is, paradoxically, simultaneously reflected and concealed in dialogic performances of not-knowing. Let us examine each in turn. First, power is reflected in the *requirement* of not-knowing; in the requirement that something different needs to be done, by the therapist, and on an ongoing basis, to make the relationship appear equal; and in the realization that dialogue does *not* spontaneously occur in therapy, but has to be carefully engineered and constantly managed by a dialogical "architect" (Anderson and Goolishian, 1988, p. 384). Therapy is a situation that seems, in the absence of specific (dialogue-enhancement) techniques, to incline more towards monological than dialogical interaction.

And in that context, I submit that the special speaking conditions of dialogical therapy constitute a technique, or therapeutic discipline, for the protection of clients against the dangers and limitations of monological forms of interaction. The distinction of not-knowing practices from other "knowing", "modernist" (Anderson, 1997), expert, and hence, monological therapies, points not only to the therapist's non-exercise of power in dialogical therapy, but alludes, significantly, to the client's *vulnerability* to exercises of power. To the extent that monologic accounts are widely available and widely practiced, clients are exposed to the possibility of power – and are hence vulnerable to its effects - in a way that is not evident in many ordinary social interactions (e.g., extract 1). But the client is not rendered invulnerable to power tactics in not-knowing therapy: that is not within his or her control, since she or he typically does not determine what style of therapy will be used, and indeed may not be aware of the options in this regard. Further, what is to stop a not-knowing therapist from lapsing into bouts of authoritarian, monologic meaning imposition (e.g., that of extract 3)? And if this does occur, could a client's resistance be as effective as was Mark's resistance to Joe's constructions in extract 1, and thereby shift the relation of power? There are no formalized protections for the client against such practices in a therapeutic relationship, and they are, indeed, routine in many forms of existing therapies. And so it is left to the *therapist* to determine whether therapy will be dialogical or monological in orientation, to decide the extent to which she or he will (or will not) "know", play expert, impose meanings, or silence and transform the client's narrative.

The need for special speaking arrangements reveals the client's vulnerability to power. This vulnerability is a product, an effect, of an a priori power relation between therapist and client. It testifies to the therapist's *ability* –

his or her entitlement - to exercise power. And although she or he may *choose* not to do so (Anderson, 2001; Anderson & Goolishian, 1990), power is nevertheless exercised: power produces for the client a position of vulnerability; and for the therapist a position of privileged access to social, professional, legal and "ethical" (in the sense of formalized ethical codes) *entitlements* to practice monologically, to exercise power and knowledge. The therapeutic refusal to actualize or deploy these entitlements does not remove the client's vulnerability, but merely serves as a therapist's promise not to take advantage of their respective subject positions. Thus, dialogical therapy joins all therapies in the presupposition of a power relation; and through the not-knowing therapist's relatively distinctive and continued guarantees and demonstrations (to the client – as shown in extract 2) that he or she will not purposely exercise power, the power relation is inevitably reproduced. Such a promise, and the requirement of a continual supply of evidence to support it, only makes sense if it comes from one who is positioned with access to power.

On the other hand, power is *concealed* as a decontextualised, specifically local view of power misleads therapists into believing that not-knowing practices and egalitarian intentions can remove traces of power from therapy. That is, power is concealed when it is discursively detached from the socio-political and cultural context, seemingly something an individual (i.e., the therapist) can choose to avoid or eject. As has been argued, socio-political and cultural practices install therapists with entitlements to exercise power; to act on and shape the client's actions. These warrants produce for clients a subject position infused with vulnerability to the therapist's intentions and practices. The client's vulnerability is not constructed via the therapist's intentions, nor is it necessarily produced in the dialogue between therapist and client, but is a function of the therapist's social, cultural and professional standing as an "expert knower", on the basis of which exercises of power can be legitimised. And so, by mis-locating power, by seeing it as constructible and/or removable within the local relationship, the inheritance of power – and the therapist's status as heir - is concealed. Thus, the speaking *position* from which the dialogical therapist delivers his or her (not-knowing) statements, questions, or opinions is ignored.

6.6. Conclusions

I want to make it clear that I consider dialogical therapy to be respectful of clients, and conducive to ways of talking that transcend expert, meta-theoretical discourses of personality, problem formation and problem resolution. Indeed, these ideas are a resource in my own work. But given the significance of power, it is important to reflexively question the concepts and practices that we so easily take for granted. Specifically, the concept of dialogue may require expansion to include, rather than exclude, considerations of power.

As a multiplicity of forces, power cannot merely be controlled by the therapist/client dyad. Thus, regardless of attitude or intention, power is revealed in the therapeutic requirement of special speaking arrangements that are *not* dialogical necessities in many other forms of social interaction. These arrangements are required because of the relatively stabilized and enduring power relation that has already been set up *for* the therapeutic encounter, by the

broader discursive and institutional factors that serve as a context for local therapeutic discourses and practices. Therapeutic participants inherit a power relation in which clients are rendered vulnerable to the therapist's entitlements to act in powerful ways. This vulnerability cannot be undone by local intentions or practices: it can only be met (in dialogical therapy) with persistent therapeutic assurances that it will not be misused or taken advantage of. And so a power relation is both presupposed and reproduced.

The problem is that dialogical therapy theory does not overtly acknowledge this aspect of the relationship. Consequently, there is a failure to adequately distinguish (1) *what* we say and *how* we talk, from (2) how we are *heard* (c.f., Young et al, 1997). Also obscured from view is the local impact, on our practices, of socially and institutionally derived entitlements to speak in certain ways (as discussed above, and in chapter 2), regardless of the ethical or philosophical stance we choose to adopt. And so the client's vulnerability is ignored at a conceptual level, which hampers the degree to which we can properly understand the experience of clienthood, and the relation of power in which she or he becomes positioned as therapy is undertaken. It seems that not-knowing practices and conceptualizations of dialogue do not resolve these issues so much as conceal them.

My argument is *not* that clients are powerless, destined to be subjugated to a therapist's preferred discursive practices. Both therapist and client are positioned in, but can also invoke, a range of discourses in their interaction, of which therapeutic discourse is only one. In a therapeutic discourse, expectations of conduct embrace both participants (as argued in chapters 2 and 3 – see also Rose, 2001). But a client is also at the terminus of *other* forms of power, such as those afforded him or her by discourses of professional ethics and legal rights (Fish, 1999). She or he may invoke these discourses, for example, in the case of therapist misconduct – although not, as has been noted, in the "ordinary" case of therapist impositions of meaning - to shift the power relation: the client now being positioned as the potential agent of the discursively articulated, professionally and legally sanctioned power to report, and perhaps even disenfranchise an abusive therapist. Within therapeutic discourse, the client has access to power in the form of resistance: she or he can walk out at any time; refuse to speak; refuse the therapist's suggested meanings, and assert his or her own forms of self-knowledge. These are features of power *in that* they are resistances. Resistance here is a kind of counter-power, implicitly or explicitly proposing alternative ways of being and relating. While resistance does not remove the therapist's inherited power (or therapy's institutional status), it may provide a temporary, transient challenge, albeit only in that local instance.

Finally, I suggest that dialogical therapy's status as an instance of a broader therapeutic institution has been understated. The distinguishing features of this approach have been well noted, particularly on the basis of knowing versus not-knowing (e.g., Anderson, 1997, 2001). But, in order to adequately theorize power, we also need to consider what collaborative therapists have in common with other forms of therapy. Specifically, it seems that all therapists share a socially constructed position as knowing-experts, a position against which not-knowing practices are targeted. Nevertheless, this shared position is supported by other factors: the perception that we have specialized knowledge; the need for

formal training; the charging of fees; even the need for formalized protections, for clients, in the form of professional ethical codes of conduct. We share in our entitlements to apply knowledge and exercise power. And we also have in common our engagements with a particular "category" of person – the therapy client – who, in assuming this position, is rendered vulnerable to therapeutic power by virtue of these entitlements. We share all of these aspects of our work – and indeed many others - with other forms of therapy. And as we share common features, in broader discursive and institutional processes, we also share in the inheritance of power. Thus, future explorations might include a more detailed examination of how these "common factors" impact on dialogues and relationships with clients. It may then become possible to re-theorize therapeutic dialogue so that it makes visible, rather than conceals, the workings of power.

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CHAPTER SEVEN
FREUDIAN PSYCHOANALYSIS AS EMANCIPATION: A CRITICAL ENGAGEMENT WITH HABERMAS[7]

7.1. Introduction

While the previous chapters have focussed on power relations within the therapeutic setting and commented on aspects of their relevance to broader societal networks of power, chapters 7 and 8 focus on the idea of critical therapeutic practices that question or challenge these networks. While chapter 8 explores the critical possibilities of narrative therapy, this chapter focuses on psychoanalysis via Habermas' claim that its practices are critical insofar as it enables and legitimizes participation in political processes.

Does psychoanalysis function critically in relation to societal networks of power? Two clarifications are needed at this point. First, this question orients around the clinical practice of psychoanalysis rather than its social or political theoretical forms, and refers to its capacity to promote *in its analysts and analysands* a challenging of societal mechanisms of power. Second, there is the question of "which psychoanalysis"? Habermas – one of the chief protagonists of this chapter - focuses explicitly on Freud, but I aim to move beyond that starting point to recognise psychoanalysis' heterogeneity, although its many manifestations may be seen to share a fundamental orientation to the idea of a "dynamic unconscious" (Frosh, 1987, p.2). Perhaps then it is permissible to speak about classical Freudian, Object Relational, Interpersonal, Ego and Self-psychological approaches, as participants in an overall strategy of analysing the unconscious. This is not to suggest, as Wallerstein (1992) does, that a clinical convergence underlies these theoretical differences, or that they do not matter to the project of constructing critique. Therefore, in this chapter some sensitivity to the range of self-identified psychoanalytic approaches becomes important.

The first significant thing about the question of psychoanalysis' relationship with power is the polarization of opinions that have emerged to answer it. Some argue that psychoanalysis can challenge systems of power, subvert dominant ideologies, and unsettle normative prescriptions (e.g., Berger, 2002; Habermas, 1972/1987; Rustin, 2005), while others accuse it of conformity, adaptationism and authoritarianism (e.g., Ingleby, 1987; Madison, 2005; Masson, 1992). While each side is cogently represented, neither can claim to have provided a decisive answer. To complicate matters, evidence is easily cited to support both sides of the debate.

This chapter take an extra-psychoanalytic perspective to the question, because the priority here is not psychoanalysis itself, but critique. We need first to articulate what we mean by power, and then what we mean by critiques of power, *before* exploring what could be meant by a critical psychoanalysis. Psychoanalytic formulations of its political leanings have been produced, predictably yielding contradictory accounts (e.g., Domenici & Lesser, 1995; Frosh, 1987, 1997; Marcuse, 1966). However, approaching the question a priori from some psychoanalytic perspective – questioning the nature of a person's political

[7] Chapter based on: Guilfoyle, M. (submitted). Grounding a critical psychoanalysis in frameworks of power.

participation solely in terms of psychoanalytic discourse - inverts the proper analytic sequence and presumes that societal power relations are by-products of fundamental psychoanalytic processes. Psychoanalysis is thereby reproduced as a relatively immune-from-critique ground upon which to formulate critique and power. I therefore bracket psychoanalytic theorising initially, and privilege frameworks that begin in a different place, posing first the question of societal power dynamics. We might then be in a better position to attempt what Blackwell (2003) calls a "radical political analysis," with psychoanalysis not merely the instrument but also "the object of … analysis and critique" (p. 33).

Two frameworks for analysing the psychoanalysis-power relationship are considered. First, the conceptions of society, power and critique proposed by social theorist Jurgen Habermas are discussed. Focus falls on his discussions of Freudian psychoanalysis as an "emancipatory practice" in *Knowledge and human interests* (1972/1987), although subsequent developments in his theorising will also be introduced at relevant points (e.g., 1974, 1984). Here, psychoanalysis functions to clarify power-induced distortions of self-understanding and social interaction. Habermas provides a useful point of departure because he examined psychoanalysis specifically from a wide-angle perspective of societal power operations. In effect, and this must be a possibility if we are to be critical, psychoanalysis becomes expendable in the quest for a critical theory and practice. Habermas argues that critique must be external to the power mechanisms it addresses, and I will argue that this feature of his theorising fundamentally limits its capacity to help us understand the possibilities of a critical psychoanalysis.

In response, I outline an alternative view of social action based on Foucault's formulations of power (e.g., Foucault, 1980, 1988, 1990; Hindess, 1996; Ingram, 1994), which takes special account of Falzon's (1998) dialogically oriented developments of his work. As already noted, this view emphasises power's immanence in social relations and the consequent impossibility of practicing from outside of power, now considered a shaping rather than distorting force. I suggest that this account permits a more meaningful view of critique, as lying within rather than independently of power relations. It is in relation to such an account that clinical psychoanalysis might consider finding its place.

And this, I suggest, is why the question of this chapter really matters: If psychoanalysis only exists in internal relation to systems of power, then it is already a political agent that participates in the shaping up of societal processes. Thus, while Frosh (1987) warns that arguments positing that "social changes come about through alterations in the interactions between individuals, rather than the other way around" reduce "the social to the microsocial" (p. 167), I shall argue that such local alterations are already politically significant, both in the sense that power operates within the local analyst-analysand level and in the sense that the products of such local interactions feed into political processes at broader levels.

7.2. Habermas on power and critique

Habermas is important in the overall context of this thesis, because he offers an alternative vision of power to the one, based on the work of Foucault, that I have been exploring and trying to develop here. Flyvbjerg (2000) suggests that while

Habermas and Foucault are very different in their visions of power and critique, they also represent the shadows of each other's positions. Thus, even though I challenge at a fundamental level Habermas' views on the possibilities of a critical psychoanalysis, substantial room will given to the explication of his ideas on the subject.

7.2.1. Power's distortion of social action

Habermas (1972/1987) proposed that human beings have three kinds of "interests", which are products of cultural and historical forces traceable to our Enlightenment heritage. He argued that all human action can be seen in terms of the dynamic interplay of these interests. Firstly, we have a "technical interest" in controlling nature, which involves an "instrumental" or "purposive-rational" rationality in terms of which natural resources are seen as manipulable, utilisable and expendable in accordance with predetermined strategies. Secondly, we have a "practical interest" in communication, mutual understanding, and the achievement of consensus free of constraint, persuasion and manipulation. This interest produces an intersubjectively oriented rationality, and is ideally the primary shaping force of human interactions. It is expressed in what Habermas (1984) termed "communicative action," the gold standard of which is the "ideal speech situation". Here, differences of opinion, ranging from arguments between friends to large scale political debate, are resolved not through the manipulation, persuasion, and strategic intentions properly associated with an instrumental rationality, but through mutually respectful, dialogical and consensually oriented means, in which only the universally agreed "best argument" determines the outcome. For Habermas, this is what people really want of their interactions.

The relationship between these interests, and the rationalities and forms of action with which they are associated, is key to understanding Habermas' positioning of psychoanalysis with respect to power. Ideally, purposive-rational actions aim at the natural domain, while communicative action orients to social interaction. However, for Habermas the biggest problem we face today is the colonisation of the social arena by instrumental rationalities that properly belong to enactments of the technical interest. This colonisation produces what he termed a "technocratic consciousness," involving the "*elimination of the distinction between the practical and the technical*" in self-understanding and interaction (1988/1994, p. 200; emphasis in original). When this happens, communicative action is deformed into "strategic" action (Habermas, 1984, p. 285), where power rather than understanding characterises human interactions. The other becomes an example of, and is rendered subject to, one's own ways of thinking and doing. She or he is utilised, exploited, manipulated and made serviceable to one's own strategic objectives; and an orientation of success and taking sides rather than of mutual understanding is taken to the resolution of disagreements. For Habermas, this distortion of the interest in mutual understanding is the result of power's operations. Power is seen to distort self- and other-understanding, impede competent communication, and make impossible the full attainment of democratic social conditions in which achievement we have an allegedly universally shared interest.

It is in these conditions that the third human interest emerges: an emancipatory interest in being free of the effects of power. For Habermas, Freud's psychoanalysis is uniquely capable of clarifying and promoting this interest, and he thereby grants it the status of critique. While power in the form of strategic action has the effect of systematically distorting communicative processes, critical activity such as psychoanalysis functions in the service of the emancipatory interest to enable the restoration of interaction to its desired, undistorted, communicatively oriented state.

7.2.2. Critique, psychoanalysis and the challenging of power

For Habermas, critique refers to practices that make visible, and hence open to negotiation, the power tactics that deform the orientation to understanding. He valued psychoanalysis because it orients, through the conversion of unconscious elements into consciousness, towards the identification and resolution of distortions in self- and other-understanding produced by operations of power during socialisation. He interpreted this as the overcoming of the irrational, which, it should be noted, misrepresents Freud's position both on the unconscious and on the task of psychoanalysis (Craib, 1989; Steuerman, 2000). However, my concern is not whether he is faithful to Freud's vision; it is clear that at numerous points he is not, and he outlines what many might consider a paradoxical creation, a rationalistic psychoanalysis. Rather, the question here is whether his theoretical system permits a reasonable analysis of the relationship between psychoanalysis and societal operations of power.

Habermas' version of critique emerges out of a dualistic model of society (Elliot, 1992); its fundamental purpose being to separate communicative from strategic orientations to interaction. Conceived in this way, critique cannot be hermeneutically self-guided. Technocratic consciousness blinds people to the dynamics of their subjective and interactive distortions. The two primary orientations often merge imperceptibly to the point that much strategic action is empirically indistinguishable from pure communicative action. Distorted perceptions compromise persons' abilities to tell which is which. Therefore, Habermas argues that a critical theory like psychoanalysis is needed to lend clarity. Through it, analysands are guided towards recognising where in their personal histories the orientation to communication, and hence their capacity for democratic engagement, was interrupted: where their original words were repressed and removed from the public domain.

The need for an expert critical theorist is central in Habermas' account, even as he simultaneously expressed discomfort with it. He noted that "the vindicating superiority of those who do the enlightening over those who are to be enlightened is theoretically unavoidable"; but at the same time he argued that this idea is in the end "fictive and requires self-correction: in a process of enlightenment there can only be participants" (Habermas, 1974, p. 40). A conceptual problem emerges then when we consider the power imbalance of the analyst-analysand relationship, which Habermas acknowledged. The expert position of the analyst as critical practitioner comes into conflict with the idea of power as a distorting force; of power as the modus operandus of strategic action, and the producer of technocratic consciousness. Thus, the clinical power

imbalance means either (1) that the analyst distorts the client's communications or (2) that there is a different sort of power involved in that instance.

The first possibility - the analyst who distorts communication – de-legitimises the critical practitioner's attempts to challenge systems of power. Under such circumstances, psychoanalysis becomes an example of the very kind of strategic action for which it is offered as a cure. For Madigan (2005), this is the fundamental limitation of Habermas' hopes for psychoanalysis. Nevertheless, Habermas tries to avoid this possibility, not because he is committed to psychoanalysis per se, but because he is committed to a *non-strategic idea of critique.* He is left then with the second option, and discriminates between power operations in terms of their legitimacy. Thus, he argued that psychoanalytic power is the power of "therapeutic critique" (1984, p. 21), the legitimacy of which rests both on its orientation to *future* – rather than current, within-session - communicative action, and on the consensual nature of the psychoanalytic relationship itself, in the form of the analysand's prior consent (Giddens, 1982). It is therefore distinct from the power of strategic action.

In taking this stance, Habermas extends power from its sole original location in the category of strategic action, to being a feature of critical action too. Power is thereby doubly positioned: it distorts communication on the one hand (strategic action) and helps clarify communication on the other (critical action). The expansion of power's functioning is not problematic in itself, but it is a significant move, entailing recognition that critique is an *example* of the exercise of power. Now, it must lie within rather than outside of the societal field of power relations. Psychoanalysis as critique thereby inherits an altered function, not explicated by Habermas, which is to *utilise* the power invested in its practitioners and practices - by some of the very societal arrangements it wishes to challenge – to promote critical action in its analysands. This idea of the strategic utilisation of psychoanalysis will be elaborated below.

But there remains the problem of communicative action itself, which if Habermas is correct, is what psychoanalysis in the end makes possible. Is it plausible to have on the one side the power of strategic action and on the other side the power of critique, with a power-free domain of communicative action in between? This creates an image of a fragile and vulnerable populace, caught between the forces of good (critique) and bad (power), but in relation to which its members are not competent, owing to the prevalence of systematically distorted communication, to make a rational choice. However, we need not hold onto this image, because pure communicative action as Habermas conceives it is not an empirical possibility (see below). Indeed, in time he would acknowledge the immanence of power in the social arena (Ingram, 1994) – including in communicative action - but unfortunately this admission was not accompanied by a reformulation of psychoanalysis as critique. I turn now to explore some of the difficulties associated with the idea of a pure communicative action, in order to establish the idea of power's immanence as a more meaningful starting point from which to understand the tasks of critique, and out of which the possibilities of a critical psychoanalysis can then be examined.

7.3. Power's immanence in the social arena

The impossibility of pure communicative action is first noted in Habermas' proposal that this form of action has counterfactual rather than empirical status (Ingram, 1994). It may be something towards which our Enlightenment heritage orients us, but it is not empirically attainable. Nevertheless, Habermas suggested it remains a goal that critique could push towards, even if it is never achieved. Social action then becomes measured by its *degree of approximation* to this ideal standard. This idea is problematic, although, as shall be discussed below, there is something within it that may be of value to a critical project, and which might help clarify something about how psychoanalysis could contribute to such an endeavour. I will first explore some of its problems.

First, nobody can ultimately decide what counts as a close approximation to the ideal speech situation, because any interaction that appears consensual is easily revealed as having strategic components (c.f., Giddens, 1985; Hindess, 1996). Indeed, it may only be in cases of overt domination or obvious psychopathology (c.f., Crossley, 2004), that we can be certain that action is *not* purely communicative: where we can say that force is used blatantly in the former case to achieve an objective; and perhaps that force *was* used in the latter case (i.e., during socialisation) to distort the person's capacity for dialogical engagement. While we can say when a situation is obviously infused with effects of power, we cannot say with any confidence when it is not. Not only is pure communicative action empirically unattainable, but even the best experts cannot definitively tell us when it is "nearly" achieved.

Second, Habermas proposes what we might consider "entry criteria" to the ideal speech situation: some people are apparently better equipped than others to approximate proper democratic dialogue and to participate in the intersubjective construction of norms. This reveals something of the concealed authoritarian and hierarchical leanings of Habermas' views (Falzon, 1998). His position - that persons are capable of proper critique and democratic engagement only to the extent that they understand and have overcome (for instance, through psychoanalysis) their once "distorted" views of self and other – at least implicitly constructs a world divided into qualified and unqualified democratic participants. In this vision, psychoanalysis is given the task of helping the unqualified - does this mean all of its analysands, or *everybody* who could become an analysand? - to "evolve" towards proper democratic participation and the capacity to share in the construction of universally agreed upon best solutions. So, while Habermas does not specify dialogical outcomes, he makes room for their specification: good outcomes are those constructed by those most qualified to participate. But we are still left uncertain about who is qualified and who is not. This hierarchization of societal participants (c.f., Giddens, 1985) is clearly exclusionary. The attempt to set communicative standards independently – or, from the outside - of the dialogical situations with which it is concerned, amounts to the construction of rules of engagement. Those who agree, and who are deemed capable of adhering to these rules are given the status of legitimate contributors. The implication is, for our purposes here, that the "analyzed" person is more qualified than some (as yet un-named) others to engage in meaningful political debate. Habermas sees this ascription of legitimacy, to some speakers and not others, not as the granting

of strategic favour in the domain of power relations, but as recognition of the most rational position from which to speak. Such a view reifies psychoanalytic knowledge and sanctifies its practices, and easily leads to the disqualification of alternative voices as irrational.

The third problem, arising from the above, is that the critical theorist – in this case, the psychoanalyst - whose task it is to enable such democratic participation, is now problematically positioned. In facilitating an approximation of pure communicative action, that person acts not only in idealistic fashion (given Habermas' concession of its ultimate unattainability), but also strategically. We have already seen that critical action so conceived creates a politically troubling distinction between the authoritative critical theorist and a vulnerable and ignorant public. But now that the critical theorist cannot, in good faith, distinguish between distorted and undistorted communication, he or she becomes an authority figure who is ultimately as vulnerable as his or her clientele to reproducing power and its distorting effects.

What emerges then is an utopian and unwittingly authoritarian Enlightenment vision of a universal embracing of particular norms for the structuring of society and for the resolution of disputes; though it is a vision that conceals is own inherently strategic nature, as it undermines and de-legitimises certain ways of thinking and living while supporting others (c.f., Gergen, 1999; Giddens, 1985). But, as noted earlier, the idea of approximating an ideal speech situation also has some merit, specifically with respect to the *orientation* it encourages persons to bring to an encounter. I will defer discussion on that point, and on its implications for psychoanalysis, to the following section, so that it can be considered in terms of an alternative vision of power relations.

The gradual erosion of the plausibility of a sharp strategic-communicative distinction eventually led Habermas to concede not only that pure communicative action does not exist but that power was indeed "everywhere" in society (Ingram, 1994). This concession of power's immanence enables us to consider society rather differently: in terms of a network of power strategies, which need not be deliberately or consciously supported, but into which we are nevertheless interpellated merely by choosing from a set of culturally salient and "common-sensical" life options. If power is immanent in social relations – which is to say that society in general, and communicative action in particular, is constituted by and constitutive of a broadly conceived strategic action - then the concept of distortion cannot be used to articulate its effects; for we can no longer hold onto the idea of a power-free communicative domain against which to compare these distortions. And of course, this changes what we can mean by critique, and what we can mean by a critical psychoanalysis.

7.4. Power, critique and strategic action

Instead, I propose that we consider power a "shaping" rather than distorting force. If power is an intrinsic feature of human interaction, then it simply functions to "make things happen", to give shape to social realities (Foucault, 1980).

As a shaping force that is immanent in the social sphere, power is not something that can be eradicated; we have instead to engage with it. People can

either choose to adopt certain strategies, or risk integration into existing strategies in more docile and unknowing fashion: avoiding power is not an option, and it makes little sense to speak (as do Habermas and Freud) of being *liberated* from it. Power's immanence does not mean that the only options open to persons are to be manipulative and exploitative, or docile and manipulated, as implied both in Habermas' version of strategic action and in Foucault's (e.g., 1977) earlier accounts of power relations. The observation of resistances against unwanted strategies demonstrates the emptiness of a docile account of human beings (e.g., Foucault, 1980, 1990). So we need to extend our account of strategic action beyond that of Habermas, to include the factors of conditioned choice and resistance. Further, and as noted in the previous chapter, strategic action cannot be seen solely in terms of conscious intention (as implied in Habermas' references to strategic and instrumental attitudes and cognitions), but must be also seen in terms of the *effects* of person's actions – intended or not. Following Foucault (1988) then, when persons oppose strategies that threaten (deliberately or otherwise) to incorporate them or change some desired aspect of their lives, their resisting actions become in themselves exercises of power, standing at least partly in opposition to other exercises of power. Resistance is a form of power in that it uses overt or covert force to weaken or neutralise the force of that which threatens to subsume it. Unlike in Habermas' account, resistance cannot aim to resolve power, and cannot be oriented *against* power per se, because - at least initially – it is woven and must speak into a particular power relation. But what it can do is to *alter from within*, the mechanisms, points of application and organisation of power relations.

This is less a total replacement of Habermas' account than a re-ordering of his proposed forms of action**.** Critical action (in the form of resistance) and communicative action (in the form of mutual respect and consensus seeking) are both subsumed under a broader form of strategic action. Any attempt to engage either in understanding or in overcoming power occurs inescapably within an overall strategic situation. So, while a successful resistance might undermine power and transform its operations (as per the emancipatory interest), in contrast to Habermas' account there is no conceptual difficulty here in seeing it as doing so through the use of its own operations of power, and which in the process might generate different kinds of power arrangements, rather than a utopian communicative social domain. And so if Habermas is correct that persons have an emancipatory interest then we must alter what it means to have this interest realised. Resistance, which may or may not incorporate consensus seeking and mutual understanding (that is, it may *appear* strategic or communicative in Habermas' terms), becomes the mechanism by which something like an emancipatory interest is attained. But the achievement of emancipation is now subjectively and locally *experienced*, rather than ontologically attained and universally applicable. Further, it helps give shape to a different order of social realities; but, even as a new form of power, it cannot be said to "distort" these realities. Successful resistances cannot avoid producing yet further power arrangements.

The localisation and multiplicity of resistance is important here. A point on which Habermas and Foucault agree is that there are many more *sites and types* of inequality, discrimination, oppression and so on than a monolithic, centralised

notion of power can account for. Capitalist societies have become considerably more complex than depicted by Marx (Giddens, 1985), and so we can no longer consider power and resistance merely in terms of globalised class struggles. Power is not centralised, but rather is exercised in multiple social arenas and in the service of multiple and often contradictory strategies. This means, as noted by Foucault (1997), that resistances are situation-specific and oriented against, though from within, particular local operations of power. In such a theoretical context, the legitimisation of resistances from some central or external source (e.g., a critical theory) becomes problematic. Foucault insists that such validation can only occur internally. That is, there can be no external criteria for validating resistance, for granting it legitimacy, without presuming a "Gods-eye-view" and thereby lapsing into authoritarianism. Indeed, the use of a universal standard, as per Habermas, to decide on whether or not a resistance is legitimate, or to shape it so that it *becomes* legitimate (e.g., through psychoanalysis), is an authoritarian gesture infiltrating a situation from the outside. It is therefore of questionable legitimacy.

However, because there is no point outside of the shaping effects of power from which to distinguish legitimate from illegitimate resistances, we are left with a thorny conceptual problem. By removing the concept of distortion emphasised by Habermas, we seem to have been robbed of the conceptual means for making such a distinction. We are left with, on the one hand, an apparently relativistic Foucaultian stance with no absolute external grounds for legitimising critique, which Habermas cannot permit; and on the other hand a more authoritarian one in which experts decide on legitimating grounds by articulating what counts as distortion versus undistortion. It is important to note that this problem arises only from a particular perspective, and is associated with an attempt to answer a particular sort of question, which goes something like this: Should we oversee social action by letting it run free, and permit its diverse elements self-validation; or should we provide a clear set of criteria according to which social relations should be organised? This sort of question conflates the task of critique with government. The question arises when *we* (critical theorists, psychoanalysts, etc) seek to validate power or resistance externally, "from above". Such distancing inadvertently assigns the critic a governmental task, consisting in the management of social relations. The accusation of "relativism" can only meaningfully be made from the external vantage point of one who seeks to impose. But when critique involves the adoption of a committed and resisting stance from within a particular power situation, such accusations lose much of their force. The question then becomes: Which resistances should we support? This is not the same question differently posed (i.e., that we should support those deemed "valid"). The function of critique is not to prescribe participation, or to classify resistances in terms of their objective worth, or in terms of the sorts of worlds they might construct should they become universal. Rather, we can consider the fundamental and perpetual task of critique to be the questioning of power, so that it does not become fixed.

However, Habermas suggests that the reluctance to adopt a normative position – as is evident in the work of Foucault - must too have its limits, or else why should we even bother to promote resistance? This is a key tension between Habermas and Foucault (Flyvbjerg, 1998). It is relevant to note in this regard that

Foucault makes an important distinction between the more shifting (and hence, desirable) dynamics of power relations on the one hand, and the more fixed state of domination. This distinction points, though perhaps only minimally, to "better" or "worse" interactions. And so we approach what might be considered the Foucaultian – though not Foucault's – version of Habermas' ideal speech situation; it is here also that we find in Habermas something important for a critical project. For Habermas, communicative action includes an interest in fair procedures and an investment in having the space, and granting space to the other, to articulate opinions in an unhindered manner. The implication inherent in Habermas' position is that persons should not *think* of each other or their interactions in strategic terms, but rather in ways that afford a respectful airing of perspectives. And in this respect, I believe Habermas makes an important point, which is not developed by Foucault.

If Foucault's normative distinction of power and domination in terms of their relationship to resistance offers a minimal view of what might count as a desirable interaction, Falzon (1998) develops his account in a way that further clarifies what this desirable interaction might look like. Specifically, and as noted in previous chapters, he promotes the notion of dialogical power relations, partly in an attempt to allow Foucault's work to make a positive contribution to social and political dynamics, rather than only deconstruction. Falzon recognised that Foucault's work is not typically associated with the notion of dialogue, but argued that his views on resistance and their relation to power dynamics can be reconstructed in dialogical terms. Thus, in a relational "dialogue of forces" (Falzon, 1998, p. 43) discursive participants can attend to and cooperatively "move" forces around, in line with their intention to respect, to hear and to discover the other. Habermas' ideal speech situation is thus converted into an interaction now recognised not as a power-free, consensus-oriented situation but as a field of moveable, dialogical force relations in which consensus is not a condition for mutual respect, and in which disagreements can be aired and respected but without the requirement of convergence. The other is thereby allowed to remain other and is not captured in one's own discourses, which is the risk of Habermas' requirement of consensus. The point here is that dialogical engagement, albeit with idealised intent, might enable discovery of something about the other's positions and perspectives that could be foreclosed by the internal adoption of a strategic attitude to disputes – even as the strategic features of the interaction continue to be in evidence. We might then argue that what is important from Habermas is not the approximation to an ideal speech situation, which according to his idealism can to some extent be measured from the outside, but – precisely – the *intention* to achieve something like it, which can only be appreciated on the inside.

This moral element of adopting certain "attitudes" to argument cannot remove power relations, but it can significantly influence their course. At this level a version of Habermas' stance - that psychoanalysis can facilitate democratic intentions via its promotion of careful self-reflection and an ethical orientation to the other - is much easier to comprehend than the discriminatory implication that it qualifies people for rational communication. In its careful teasing out of the transference, psychoanalysis might well highlight to its analysands the dangers of conflating one's reading of the other with the actual other. Through the implicit

promotion of eternal uncertainty regarding the other, and an associated desire to at least try to understand the other *as other*, psychoanalysis can facilitate the "preservation of the non-identity of one with another" (Habermas, 1972/1987, p. 157). It might promote respectful dialogical interaction outside of the analytic setting, not because it enhances rationality, but – at least in part - because it encourages not-knowing.

Thus, while Habermas' aim of power-free interaction is unreachable, aspects of the egalitarian aims he espouses in the form of a human interest – a desire for equality, fairness and respect - can be linked up with Falzon's interpretation of Foucault to help us to imagine the more attainable goal of fluid and dynamic power relations. Significantly also, it is consistent with the above proposal for a critique that is always questioning of power; not in order to remove it, but to keep it from becoming fixed. So, perhaps power's legitimacy is secured not so much by its grounding in a moral consensus, but by its willingness to be questioned and even dialogically transformed through an empathic and responsive reflexivity towards the range of resistances it will inevitably face: by its willingness to be temporary. Reciprocally, we may consider critique as the facilitation of impermanence.

7.5. Towards conceptualising a critical psychoanalysis

Drawing from the cornerstones of the preceding discussion, I propose three tasks or orientations for a critical practice, through which to consider the possibilities of a critical psychoanalysis. It needs to (1) note resistances *as* critiques of power, involving a respectful orientation to the other; (2) declare its position on the particular power formations it is interested in; and (3) demonstrate in its concepts and practices a reflexive responsivity to the dynamically changing social context. The first task facilitates the avoidance of authoritarian imposition by highlighting *what* should be attended to and *how* we should pay attention to it. The second represents an acknowledgement of critiques' internal relation to and participation in power dynamics. And the third refers to the ongoing questioning of power in its changing manifestations.

But before discussing these tasks, I wish to clarify what I mean by resistance in a way that expands on its coverage in previous chapters. The resistances to which Habermas (1972/1987) referred when invoking the work of Freud appear in some respects different from the resistances promoted by Foucault (1980) in his call for an "insurrection of subjugated knowledges" (p. 81). In the former case, resistance is specifically an intimately personal phenomenon, which refers to the de-linguistification or removal from language of certain personal experiences and the associated obstruction of the psychoanalytic process; an intrapsychic process. But in the case of Foucault, resistance typically refers to a defiance, refusal or subversion of certain cultural, economic and institutional technologies of power (that is, saying "No"), *and* to the promotion of local ways of knowing about the self and the world which have thus far been silenced or marginalised by these techniques (that is, the promotion of alternative discourses, emerging out of the "No"). For Foucault, the knowledges associated with resistance, which may be "naïve… low-ranking… unqualified… particular, local" (such as those of the patient), or more erudite "blocs of historical

knowledge", form the foundations of critique: "It is through the re-appearance of these… disqualified notions, that criticism performs its work" (Foucault, 1980, p. 82). Critique becomes the articulations and practices of resistance.

There is a hint here that the distinction between psychoanalytic and political resistance is misleading. The personal is always political and the political is always personal. Thus, there is no clear cut distinction between resistances against what we might call "macro" or "micro", even internal, techniques of power. Consider a client's refusal of some aspect of psychoanalysis on the one hand, and a woman's refusal to be dominated by sexist practices in her work or home situation on the other. In both cases the following features can be noted: (1) a "no" or a refusal; (2) a range of knowledges becoming available to construct that refusal, many of which may be inconsistent with the psychoanalytic agenda; and (3) a confluence of personal (micro) and political (macro) situations. And, furthermore, both situations can be interpreted psychoanalytically. So, on what basis do we distinguish between these two apparently different forms of resistance? The analysand's refusal may be seen to reflect a transference process; it may contain hints of an alternative view of what is going on between himself and the analyst; and it may also imply (for example) a questioning of authority in general. The woman's refusal may reflect a reaction against patriarchy; an identification with discourses of equality and feminism; and (for instance) anger at her father's dominance during her socialisation. It seems problematic to distinguish between these resistances – that of the analysand or the woman – merely on the basis of their presence or non-presence in psychoanalytic sessions. Rather, the resistances highlighted by psychoanalysis must inevitably have political implications, just as political discontent has intrapsychic implications (e.g., Frosh, 1987; Rustin, 2005). (It should be noted that some things that have come to be known as resistance in psychoanalysis – due to the tendency to label it as anything impeding analysis - may not have the interpersonal element of refusal, and so there may be some conceptual slippage here. It is likely that some analytic resistances will not satisfy these conditions.)

Resistance, then, refers here both to the micro and the macro in the sense that it is both personal and political. It can only occur in a local site – where else could it occur if not somewhere local? - and yet as soon as it is put into narrative it becomes invested with meanings that link it up with broader discourses that compete with each other at societal level to define social and institutional reality. In its initial moments it has power as its point of reference, as it refuses it. Indeed, we first recognise resistance – and for that matter, the power to which it refers – through a "No". It is here, argues Falzon (1998), that "the other or otherness makes itself felt, as that which does not just conform to the categories one imposes on it, but also eludes them, goes beyond them, and is able to affect one in turn" (p. 45). As noted in chapter 5, Foucault (1997) considers refusal to be "the minimal form of resistance" (p. 168); he thereby points to its more creative aspects. Resistance can be associated with the production of new discourses, through the gaps created by the refusal of existing knowledge or by calling forth some forgotten ideas and practices from one's remote personal or cultural history (e.g., as prioritised in White and Epston's [1990] use of Foucault to formulate narrative therapy – see chapter 8; and alluded to by psychoanalyst

Hoffman [1983/1994 – see below]). Resistance is simultaneously a refusal of what is and an implicit or explicit proposal for something else.

Let us turn now to examine the possibilities of a critical psychoanalysis with these points in mind.

7.5.1. Resistance as a critique of power

How well can psychoanalytic theory and practice deal with resistances as aspects of a power relation? This discussion flows from Foucault's understanding of the inextricability of power and resistance and of resistance as the basis of critique, but will also draw on Falzon's account of dialogical power relations and the intentions tied into Habermas' position: the idea of respectful, non-strategic intentions and openness to the other, even in the context of strategic power relations. This issue matters because resistances against the analyst, against an interpretation, or against psychoanalysis itself, are political as well as intrapsychic phenomena; political not merely in the sense of being related to a local (i.e., analyst-analysand) power relation at risk of involving impositions of meaning and a failure to respect the positions of the other, but also in the sense that how psychoanalysis deals with resistances will say something about its capacity to *hear* – and not just interpret – critiques of itself. Further, the discursive shaping up of resistances, whether in the language of the analyst or the analysand, will have some bearing on discourses and practices circulating in society at large. In this section, I will first focus on resistance within analysis, and then consider psychoanalysis' bearing on client's engagements with power outside of sessions.

The idea that resistance exists in the context of "forces" is common in psychoanalysis (Freud, 1912; Greenson, 1994); but in terms of an intrapsychic rather than interpersonal field of power relations. It is not new to argue that psychoanalytic theories in general facilitate the reconstruction of interpersonal forces between analyst and analysand as internal forces, now lying within rather than between participants. The idea of transference perhaps exemplifies this best, and it thereby threatens to undermine the legitimacy of the patient's interpersonal responses insofar as these responses are seen as profoundly personal rather than interactional: as repetitions of past experiences that reveal "the kernel of [the patient's] intimate life history" (Freud, 1926/1962, p. 141); as the enactment of "unconscious fantasy" and a "disguised communication from the unconscious" (Auld, Hyman & Rudzinski, 2005, pp. 136-137); or as Greenson (1994) puts it, as a "resistance to memory" (p. 183) giving us "clues to what is warded off" within the patient's psyche (p. 182). Such formulations undermine the integrity of the manifest contents of the analysand's speech – the local knowledges inherent therein - and create a rationale for the replacement of dialogical-communicative reflection (on what might be going on between analyst and analysand) with self-reflection. This has implications for resistance, the status of which as part of a power relation is concealed to the extent that interpersonal dissent is reconstructed to point to something else entirely, in relation to which the analyst seems to have played no constitutive role.

It is evident that one can easily use psychoanalysis to justify situating interpersonal refusal in the intrapsychic domain. But Freud argued that such relocation is not always justified. He suggested that "in some rare cases"

resistance can indicate "legitimate dissent", and advised that careful observation of the range of analysand responses to a resisted interpretation might facilitate clarity (1937, pp.262). The effect of this distinction, though, is similar to that of the difference between "real" and transference responses in the client held by some analysts: in the absence of clear theoretical and methodological criteria, other than some tautological appeal to the analyst's ability to discriminate between the real and the unconsciously perceived worlds (e.g., Auld, Hyman & Rudzinski, 2005), it is left to the individual analyst to ultimately decide on what counts as justifiable dissent.

However, the relocation of resistance into the client's psyche is not universally practiced. Let us briefly consider the examples of Hoffman (e.g., 1983/1994) and Ferenczi (Hughes, 2004). Hoffman (1983/1994) challenges analysts to avoid routine interpretation of resistances. He objects to the analytically popular term "distortion"; a term favoured by Habermas and key to his rationale for psychoanalysis as emancipatory practice. Hoffman argues that analysands frequently have plausible and perceptive insights into the analyst and the relationship - an idea expressed much earlier by Ferenczi and even by Freud (Hughes, 2004, p. 34) - and that these observations can be explored as legitimate and *undistorted* proposals. Bauer (1994) notes that Hoffman's account transforms the transference analysis "from a situation where one person acts upon another by means of interpretation, to a collaborative, two-person examination of the relationship" (p. 83). (See Mészáros [2004] for a brief history of psychoanalysis "as a mutual exchange between the analyst and analysand" [p. 105]) This interactional view is important not only for the space it gives resistance to be something other than an intrapsychic phenomenon, but also because it opens up the possibility of examining refusals as relational features that at least implicitly propose alternative ways of looking. Resistance is granted something of its creative aspect, perhaps as an entry point into alternative and legitimate client-led discourses (Hoffman suggests *potentially* legitimate at any rate). These discourses can then be considered ways of looking co-existing with others circulating in and around the encounter, and so any totalizing tendency is undermined.

This "social paradigm", exemplified by Hoffman, is elaborated in the interpersonal versions of psychoanalysis, which advocate a collaborative, "here-and-now" approach to the relationship. Here, transference is seen as an "intensified slice of life, rather than a distortion of the present by complex phantasies about which only the analyst had expert knowledge" (Bateman & Holmes, 1995, p. 45). Thus, refusal is not only given room to point to something interpersonal, but space is also made for its elaboration into alternative discourse. For example, Ferenczi, the recognised founder of this movement (Mészáros, 2004), permitted mutual analysis with some clients, in which analyst and analysand would change roles in alternating sessions. One client in particular suspected that Ferenczi had an unconscious hatred for her (Hughes, 2004). The significance of Ferenczi's radical response – mutual analysis - consists in his willingness to question power, to consider the possibility that the patient noticed something real and not imaginary, and to allow her to analyse him to find out. To his surprise the analysis revealed, in his own words, that "in fact … I did hate the patient, in spite of all the friendliness I displayed" (cited in Hughes, 2004, p. 33).

Thus, while on the one hand a psychoanalytic way of knowing is no doubt entrenched in a mutual analysis, on the other hand the client's version of events is taken to be credible and plausible enough to warrant *client-led* investigation. One could argue that Ferenczi respected the client's initial resistances – her challenging of the analyst, and of the accepted fixing of interactional roles in psychoanalysis – to the point where he gave her as much space as he possibly could to explore their full meaning. Her discourses, to paraphrase Foucault (1972, p. 49), were given room to produce into their shared social arena the objects of which they spoke - an altered and arguably more equitable psychoanalytic practice; and even the analyst's hatred for her, which could not have meaningfully informed their situation had it not been interpersonally validated - rather than simply the objects inherent in Ferenczi's own discourses. And with Ferenczi allowing himself, his actions and his understandings to be significantly influenced in the process, we can see this interaction in terms of Falzon's "dialogue of forces" (Although, as argued in chapter 6 with respect to collaborative-dialogical approaches to therapy, the fact that he had, in a sense, to "give permission" for this to happen reveals his ultimate authority in the situation). Certainly, a client's desire to analyse the analyst could be interpreted as a transference phenomenon; the analyst's allowance of this can be similarly analysed. But Ferenczi's willingness to set aside such a predictable solution points to his attempt to regard the client as other; or, as Habermas might suggest, as a communicative participant.

However, if it is to be a *psychoanalytic dialogue* rather than just dialogue, there must surely be some limits. Hoffman, for example, does not allow the dialogue to move too far from its psychoanalytic base, and ensures that the legitimacy of the client's interpersonal resistances is ultimately kept in doubt, awaiting verification by the analyst. Ferenczi's mutual analysis encourages a dialogue of sorts, but arguably reinforces the psychoanalytic emphasis on not taking the other – analysand or analyst - at face value; a perpetual distrust of the other calling for still more analysis. Psychoanalysis remains the technique through which to judge the reality of each party's perspectives of the other. In both cases psychoanalysis, in all its variations, is used – problematically; but as Habermas intended – as the tool with which to measure the credibility and legitimacy of the patient's dissent. Thus, although Habermas may have misconstrued key features of Freud's ideas, he seems not far off the mark in suggesting that psychoanalysis aims to facilitate the uncovering and legitimization of patients' real meanings.

This means though, that psychoanalytic interpretations of dissent might well outweigh the patient's own versions of events – unless they have themselves come to be psychoanalytic in nature (e.g., in the case of Ferenczi's patient/analyst) - when the analyst's point of reference remains bound up in a psychoanalytic perspective. Psychoanalysis itself is thus not seriously challenged by its clients' questions, for it is distant from and stands above them. Instead, resistances against it from within (from analysands) afford it the opportunity to speak in its own voice(s) to new situations, through the advances of new techniques and refinements of its objectives (e.g., via analysis of analyst resistance; of the relationship itself; of each other). In the process, certain key objects of psychoanalytic discourse are reproduced: the psychoanalytically shared belief in the unconscious as masker of motives and meanings; and of course, psychoanalysis itself. Essentially, these may be seen as *tactics* utilised

inadvertently by analysts to enhance the influence of the profession and its concepts, and also perhaps to strengthen their position within it.

In contrast to Habermas, Falzon (1998), in his dialogical interpretation of Foucault, argues that respect for resistance must be accompanied by respect for the ways of knowing associated with it. The "No" of resistance is in itself not yet a critique, and this is why we must attend with interest to the discourses out of which it emerged or which emerge from it. Considering the innovations of Hoffman and Ferenczi, might we imagine (and this is something that for Habermas is impossible) a reasonable challenge to be that of deferring *analysis* of these budding alternative knowledges, and of recognising within them something of vital importance to the client; not concealments and distortions, but legitimate and personally situated views? It seems that even in the more collaborative stances discussed here, alternative knowledges are ultimately subordinated to the particular analyst's position at the most primary levels: at the levels of belief in the pervasive influence of the unconscious, and of psychoanalysis itself. Critique of psychoanalysis itself is effectively foreclosed, and alternative knowledges generated within its practices seem to be eventually subsumed by it. The other who is the client is thereby incorporated into more recognisable discourse.

The task of noting resistances as legitimate responses to a power situation is essentially a question of psychoanalysis' ability both to examine its own internal power systems separately from analysing them, and to question its seemingly pervasive – totalising even – capturing of people's experiences. The point is that resistance threatens to bring in something from outside of these psychoanalytic discourses, and points to the client's difference. To be clear, I am not suggesting that psychoanalysis cannot be helpful even if it captures and redirects critiques coming from resisting analysands; only that such action limits its internal integrity *as a critical practice*. Certainly, it becomes something like what Habermas wants it to be: a tool for the tidying up and accreditation of resistances and associated ways of knowing. But I have argued that this is the part of Habermas' position that we should *not* accept; shaping up resistance to the point where it reinforces the forms of power it opposes is not considered a critical function. The key aspect of his work I have retained with modification - the *intention* to understand the other as other and to be respectful of the positions and perspectives she or he brings to an encounter – appears to be in evidence only to some extent in some of the practices I have touched on. Nevertheless, it is not clear to what extent psychoanalysis can permit an internal (i.e., within-session) "insurrection of subjugated knowledges", in the sense of permitting the growth of alternative ways of knowing that are not constrained by a psychoanalytic epistemology.

What then of psychoanalysis' facilitation of critical activity outside of the consulting room? After all, this is more what Habermas (1984) had in mind when he noted that the communicative benefits of psychoanalysis would be realised only *after* the analysis had finished. The question here revolves around the client's challenging of power operations that lie external to psychoanalysis itself, but which form part of the psychoanalytic "discussion": the woman who discusses her intimidation by the men in her life; the man who is angry at what he perceives as "free-loading" immigrants; the girl who does not want to take medication; the woman who is angry and concerned about the destruction of the rainforests. Let us consider this last case in order to clarify the issues involved.

The woman concerned about the rainforests is an example briefly described by Bateman and Holmes (1995). In this case, the analyst interprets her concerns as a defensive acting out of an internal conflict. He notes that the client's mother had died recently, and that the client had cut herself and attempted suicide many times. According to Bateman and Holmes, "the analyst acknowledged her environmental concerns but stated that he believed her preoccupation with them in the session was an avoidance of her sense of personal devastation following the loss of her mother, which made her feel like *cutting herself down* and killing herself" (p. 169; emphasis added). This example is interesting and perhaps unusual for the explicitness of its juxtapositioning of an overt political position and internal psychoanalytic processes. What is significant, however, is that the interpretation offered does not in any way support her face-value concerns. Instead, it suggests that she has misunderstood her interest in the rainforests. The tricky use of the phrase "cutting herself down" is a rhetorical device that strengthens the association of the client's self-harm with her interest in the environment. It both deepens and concretises the interpretation itself, by constructing her observable behaviour as a kind of mirror of her internal processes. But the two features – political interest and psychoanalytic process – are not evenly managed. Because they do not precisely reflect each other as equal or perhaps even genuinely co-existing possibilities, it seems that the client is positioned in such a way that she must choose: reject the interpretation in order to experience the reality of an environmental concern for which much of the world's scientific community would commend her; or accept the interpretation and see the environment – though "acknowledged" by the analyst - as merely a stand in, a symbol, for the reality of the client herself. The person-politics association established within the interpretation undermines the validity of the political and reifies the personal by making the former a by-product of the latter.

Some analysts might agree with the analyst's take here, while others might highlight the status of the case as, quite literally, a textbook example, and consider it functional to the purpose of clarifying basic analytic thinking at an introductory level. But I use this example to highlight the *ease* with which clients' implicit or explicit participations in power relations outside of analysis, and their understandings of their behaviour generally, can become unsettled via psychoanalytic discourse. A critical look at psychoanalysis must involve a questioning of what we might consider a bias for the personal, which becomes most apparent when we recognise that so many other biases could be used. We need only look to feminists, ecologists, sociologists, historians, economists, and so on, to imagine other possible frameworks from within which to understand a person's life situation. But in representing one or other version of *psychoanalysis*, the analyst is persuaded into analysing both the client and himself in order, precisely, to privilege and enhance what is personal for the client, and then perhaps, and more dangerously, to reduce all things to it.

The question is one of how the interplay of the political and the personal are organised in the analyst's thought and action, and to what extent being an analyst permits alternative arrangements. For example, in the case just mentioned, it is significant though unsurprising that the analyst does not interpret the client's self-harm acts as reflections of her deep concern for the rainforests, with "cutting herself" and even "killing herself" now standing in as a metaphors

for this concern. Discomfort with such an interpretation may, aside from anything else, reflect acceptance of the inequality inherent in the interpretation that *was* given: that the personal should be privileged over the political. The politicisation of the personal inherent in my reversal of the interpretation upsets the order in which things are traditionally kept. To what extent can some psychoanalysis *tolerate* exploration of competing discursive frameworks of this order with its analysands?

I suggest here a number of questions that I hope will further clarify the task of psychoanalysis' facilitation of critique outside of the consulting room. First, a general and orientating question: Is it possible to give analysands space to speak in their own insurrected terms without having their discourses analysed in a way that alters the political-strategic "flavour" of their original meanings? Is there a way of working such that certain political interests, perhaps those around which client and analyst are in agreement, are heard and legitimized - or honoured, protected and nourished? What impact does interpretation have on the client's external struggles? Consider a variety of concerns felt as important to particular clients: to protect the environment; to avoid humiliation, assault or abuse; to combat psychiatric diagnostic labels in describing one's children; to combat sexist, racist or other discriminatory practices. Note that these interests have a clearly discernible strategic flavour: protecting the rainforests is a good thing; not being beaten is a good thing; being diagnostically labelled is a bad thing; and so on. Can these political flavours, inherent in particular clients' discourses, be honoured within psychoanalysis? If analysts are prepared to privilege transference, psychoanalytic methods, insight, as good things, under what circumstances can this privileging be extended to certain political alignments?

The goals of respecting a client's resistances and facilitating political participation inside and outside of the consulting room require re-examination of the role and attitude of the analyst. The principles of neutrality (though not as favoured today as it once was), distancing, the "professional attitude" (Sandler, Dare & Holder, 1973) and abstinence, all consistent with Habermas' view, probably do not sit comfortably with critical practice as I have articulated it. But this discussion is necessarily incomplete, partly because mention has not yet been made of practitioners who are more overtly involved in linking up the personal and the political through clinical psychoanalysis, and who more clearly "advertise" their locations *within* rather than outside of the societal field of power relations. This then is the second major undertaking for a critical psychoanalysis: it needs to "take a stand".

7.5.2. Taking a stand

In my earlier challenge of Habermas' notion of pure communicative action, I argued that we inevitably occupy an internal, and hence strategic, situation with respect to power relations. Thus, in a society constituted as a "field of force relations" (Foucault, 1990, pp. 101-102) one must either take a position on certain political issues, or be invested with positions indirectly from alternate sources. Indeed, one can interpret psychoanalysis' political polarisation, noted at the outset of this chapter, in precisely these terms. That is, the range of strategic forms it takes - from, for instance, the homophobic, sexually prescriptive

practices that dominated its practices during the twentieth century, to the increasingly popular pluralist and non-prescriptive forms – do not tell us so much about psychoanalysis itself, as its flexible capacity to become integrated into any number of culturally available strategies of power. Foucault has shown that truth can be used to support a variety of strategies: even expert discourses can have strategic or "tactical polyvalence" (1990, p. 100). And so while a truth oriented psychoanalysis will have political effects, these effects are likely to be indeterminate and unpredictable in the context of society's strategic heterogeneity. Psychoanalysis can be attached to any of the number of political strategies made available to it.

Sometimes this diversity is associated with the thinly veiled adoption of political agendas. For instance, analysts convinced that "homosexuality" is a natural category of intrinsically pathological persons (e.g., Bergeret, 2002; Socarides, 1996) align with broader movements that marginalize or exclude persons so categorised; and analysts who are committed to the disqualification of this idea (e.g., Domenici & Lesser, 1995; Frosh, 1997) become directly or indirectly aligned with corresponding cultural strategies. Psychoanalysis is indeed capable of taking strategic sides, even as at the same time – and on both sides - the strategic nature of its practices is concealed as they are constructed in terms of the quest for apolitical, non-strategic "truths". But what is striking is that psychoanalytically oriented thinkers often consider side taking to be somehow "un-psychoanalytic". The analyst is supposed to suspend pre-judgement, and to adhere to a rule of abstinence (Frosh, 1987). Thus, it seems there is typically a non-declaration of the strategic interests supporting analysts' actions. Indeed, even those who object to the pathologization of homosexuality give the impression of lacking political commitments in this regard. Here, there may be a reliance on scientific and "proper" psychoanalytic methods to reveal the truth. For example, some highlight methodological problems associated with psychoanalysis' pathologization of particular forms of sexuality (e.g., Frosh, 1997; Meyers, 1999; West, 1977). But this surely is a risky business. There appears in some cases to be a reliance on scientific psychoanalytic methods to tell a *particular* truth about gay and lesbian sexualities. What guarantee do we have that science, or psychoanalysis, will tell the truth we feel – at this moment in our culture – is the "correct" one? (It should be noted that some psychoanalysts appear to resolve this problem by simply pathologising *everything*, including all forms of sexuality [e.g., Chodorow, 1992])

The problem with a reliance on independent methods for discerning truth is that scientific knowledge can only speak into specific historical and cultural contexts; they are themselves given shape by the relations of power in which they are inextricably bound. So, the issue of today is not that psychoanalysis – even a scientific psychoanalysis - can or cannot tell us who is mad and who is not; but that in more widely accepted pluralist and tolerant societies, it is not considered appropriate to even ask, let alone attempt to answer in any systematic way, certain questions whose very posing is imbued with connotations of insensitivity, intolerance or discrimination. For instance, "homosexuality" per se - and it is in principle obviously the same with any culturally constructed form of sexuality, heterosexual or otherwise - is no longer pathologized in "correct" analytic circles. And yet we cannot claim that science and psychoanalysis has uncovered its real

status. Rather, it seems more likely that scientists in general, and psychoanalysts in particular, know that this is no longer a legitimate question to ask. Thus, while discrimination against self-identified gay and lesbian persons continues to be a culturally available political strategy, it is increasingly deemed an illegitimate - and in some cases, illegal (Twomey, 2003) - strategy for psychoanalysts to adopt. Nevertheless, it should be noted, exclusionary and divisive versions of psychoanalysis continue to be sustained (e.g., Bergeret, 2002) by their normative "homing" within discriminatory discourses and practices that remain available in the broader culture.

The commitment to truth and to a pure psychoanalysis obscures the manner in which psychoanalysis is invested with particular political strategies that are not inherently its own. If this is the case, then Habermas' claims for its independence of these strategies is obviously undermined. In some cases the psychoanalytic attachment to truth seems to belie an undeclared a priori commitment to certain ways of thinking about and acting towards (for example) persons of a range of sexual orientations (e.g., in anti-homophobic ways). This is not so much psychoanalysis guiding the analyst, as the analyst's undeclared strategic utilisation of psychoanalysis. To take an earlier example, the analyst of the woman interested in saving the rainforests both conceals and reveals his undeclared utilisation of psychoanalysis to promote internalising discourses and (perhaps unwittingly) challenge the validity of ecological commitment in that case. How many other environmental advocates might be found to be acting out some internal conflict? What implications would this have for the ecology movement? This is not to suggest that he is against environmental concerns per se, but that his actions enter into a strategy by which those concerns are undermined. It is in this sense that he reveals undeclared political action. Such inadvertent or deliberate political intervention (e.g., the non-pathologization of homosexuality; promoting internalising discourses; the condemnation of child abuse; even the idea of analytic neutrality) inevitably infiltrates analytic consultations and participates in the shaping up and reproduction of much broader cultural strategies. These cultural strategies are thereby incrementally reinforced in their opposition to other (e.g., homophobic, systemic, abusive, or constructionist, respectively) discourses and practices that remain available in the culture. But it is disingenuous to suggest that certain commitments that have been seemingly legitimised and removed from the domain of opinion (for example by scientific findings) move us towards a "truer" psychoanalysis that is not inherently strategic in nature. An analyst's recognition of his or her internal location with respect to relations of power entails a strategic commitment to the shaping up of specific but in many ways predetermined, culturally specific and politically salient versions of truth: not because they are true but because this is what we want to count as truth; because this is how we want to live.

Such declaration of strategic interests can take many forms, and – as we have already seen with regard to competing views on sexuality - may well be couched in an objectivist language. To take another example, Rustin (2005) uses an object relations perspective to argue that in the UK and the USA manic defences are prevalent, and are "organised around fear of enemies and the daily amplification of threats from them" (p. 376). It should be noted that Rustin's view seems to be that this is probably "objectively true" rather than a strategically

desirable or politically useful interpretation, and so there is the risk of concealed authoritarianism once again and an overriding of clients' versions of events. But he nevertheless offers aspects of a sociologically and politically strategic vision that can permeate local practices of psychoanalysis. In his view, individual cases are vital both to help clarify the impact of ideology (as concretised, for instance, in foreign and domestic policy) on the person, and to communicate critical understandings of that micro-macro link via, for instance, their publication. In other words, we are offered here not only a politically committed psychoanalytic view, in which a stand is taken, but a view that links the personal with the political within and through clinical practice.

In the context of the overt declaration of strategic interests, the concerns raised above about the limiting effects on critique of the analyst-analysand power relationship can be reconsidered. The analyst might be more justified in engaging in interpretive and other power related activities – if this is to be a critical psychoanalysis - if the analysand has prior knowledge of the strategies towards which analysis is already disposed. Consider the client who aligns with current US governmental practices and insists that fear of the other is a healthy and necessary state. Might that person not experience Rustin's general approach – if it is not clarified beforehand - to be a process of political conversion via psychoanalysis? Similarly, gay and lesbian clients may need to know beforehand whether or not their sexuality will in itself be essentialized and pathologized through psychoanalysis. And I have already asked the question of the conditions under which the environmentally supportive client might be supported in her concerns. Open disclosure of the political standpoints inherent in one's work could make prior consent, which Giddens (1985) suggests might to some extent redeem Habermas' retention of psychoanalysis as critique in the face of its internal power imbalance, a more meaningful defence of that power relation. For Habermas, it is precisely the analyst's neutrality that makes psychoanalysis critical. However, prior consent becomes problematic when such neutrality involves the analysand not knowing, and the analyst not declaring, the analysis' particular strategic orientations. This is not critique, but disavowed or denied strategism. Neutrality conceals this aspect of psychoanalytic work under the guise of truth.

But the analyst's acknowledgement of strategic participation can at least assure the analysand of some of the political terms and mutually agreed limits under which consent is given. Certainly, the meaning of the client's words will continue to be doubted - via the concept of the unconscious, the interpretation of transference and so on - but a political limit will have been set in terms of which specific strategies might be discursively "thickened" and perhaps in the process enhanced; but not subverted. Is it somehow un-psychoanalytic for a particular psychoanalyst – who acknowledges an alliance with a particular client's external concerns – to take these views at face-value, as the views, in other words, of a fully qualified democratic participant? Can parts of Habermas' vision of democratic engagement infiltrate the psychoanalytic situation itself, so that the client's discourses, on this openly acknowledged shared issue at least, are heard on their own terms? Could these then be analysed "strategically"; so that psychoanalytic meanings deepen and further ground her challenges, rather than process them through a more detached analytic machinery? Relatedly: On what grounds is it reasonable to take an at least implicit position – and to leave that position

untested as an assumption in the mind of the analysand - on violence, sexual abuse, or racism, but not on a range of other politically significant issues that have not yet attained an equivalently unanimous level of cultural concern, and so have not yet influenced psychoanalytic trends? The danger of course is that without attention to such issues, psychoanalysis may be destined to lag behind cultural developments, and even behind its clients, around what needs to be challenged in society.

7.5.3. Reflexive responsivity

Resistance can only be relevant and potentially effective to the extent that it is intimately bound up with and enacted within *specific* relations of power. Only in this way can it be considered a constituent part of a particular dialogue of forces; as dialogically internal to the power it refers to and opposes. But the multiplicity of power's sites and techniques in modern western societies yields multiple resistances, each of which is necessarily local in nature. It has already been argued that critique recognises resistances internally, in the specific, local languages and knowledges in which they arise. Here, we note what this means in the context of changing relations and techniques of power. Local resistances are acutely responsive to the particular situations in which they are expressed. Any critique aiming to highlight and lend support to resistances must be equally capable of sensitivity and situation specificity: it must be reflexively responsive to the particular forms of the power relations and strategies it seeks to address.

In the context of multiple and diverse power operations, we can distinguish between a reflexively responsive critical practice, and what might be termed an "accidental" critical practice. The latter refers to critique (such as that of Habermas) derived from blocs of knowledge constructed prior to the specific power relations they address, that aim to be independent of them, but which in particular situations *happen* to have resistance-supporting effects. The idea of the strategic polyvalence of discourse means that almost any institutional, professional or common sense practice can be used to critical *or* conformist effect in certain circumstances. Given the sheer number of power-resistance dynamics, accidental instances of critique are easily found. To take a plain example: one could, with strategic or non-strategic intent, use statistical knowledge to "show" that racist, sexist or heterosexist research outcomes are methodologically flawed. This is "statistics" as accidental critique; we would not argue that statistics is an inherently critical practice, because it plainly can be used for any political purpose. When it is argued that psychoanalysis is a critical practice, this cannot be what is intended. So we must ask, with this in mind: What capacity does psychoanalysis have to conceptually re-align itself with the range of resistance types it will encounter, so that its critiques are not merely accidental?

On the one hand, it is heavily weighed down with concepts to which it must subscribe in order to remain "psychoanalysis": the unconscious, transference and repression in particular. The strategic reproduction of psychoanalytic theory and practice is its default first priority. Even the works of Ferenczi and Hoffman, as discussed above, demonstrate a totalising use of psychoanalysis to think about the other and the relationship: about the legitimacy of the speech and resistances of the other (Hoffman); and about who should analyse whom in order to find the

truth (Ferenczi). This tendency make it difficult for psychoanalysis to attend to resistances without first distancing itself from them, doubting them, translating them, and rendering the legitimacy of their struggles conditional upon their psychoanalytic congruence. From this standpoint, psychoanalysis seems limited in its capacity to display the sensitive responsivity of a critique *that must change* in order to add its support to, without overly translating, the objectives of a range of resistances. Psychoanalysis' orientation to its own truths over and above political participation seems to render it strategically sluggish, lacking the dynamic reactivity and capacity for rapid self-transformation that is required for meaningful critique. Thus, while psychoanalysis can have critical effects, it tends to lag significantly behind socially emergent resistances (Blackwell, 2003; Blechner, 1995). It is interesting then to note that it is this seeming independence that made psychoanalysis an exemplary candidate for inclusion as critique in Habermas' theory of human interests. But from the perspective of those who seek support in their resistances, it is this very feature that slows it down, makes it prone to authoritarianism and to accidental critique, and limits its ability to sensitively orient to power's multiple and diverse manifestations.

However, this apparent sluggishness is cautiously noted. A more optimistic possibility arises, paradoxically, out of the observation of psychoanalysis' "spreading" across the political spectrum. The elasticity of its concepts (Sandler, 1983) enables it to speak to situations in numerous ways (as is evident in the conflicting psychoanalytic accounts on sexuality noted above). Therefore, if it conceives itself as internal to power, and if it intends to be systematically critical in the sense of always questioning power, and doubting power's legitimacy (including its own [c.f., Frosh, 1987]) at least as much as it doubts the words of its analysands, then it can embrace its historically and empirically evident malleability as a resource that can be used and directed to permit multiple but now deliberate strategic engagements. Perhaps psychoanalysis could allow for its own perpetual regeneration in response to changing and often unforeseen power-resistance dynamics. This is a goal of an ongoing process - rather than the attainment of a critical "state" - towards which psychoanalysts can choose to move. But it means making psychoanalysis serviceable to tactical objectives – other than purely that of its own reproduction - rather than the other way round.

A brief account of what reflexive responsivity entails is outlined in Foucault's (1988) vision of the intellectual as one

> who destroys evidence and generalities, the one who, in the inertias and constraints of the present time, locates and marks the weak points, the openings, the lines of force, who is incessantly on the move, doesn't know exactly where he (sic) is heading nor what he will think tomorrow for he is too attentive to the present (p. 124).

7.6. Conclusions

Foucault had a notoriously ambivalent attitude towards psychoanalysis (Whitebook, 1999), ranging from his favourable reading of Freud as providing, at his time, a much needed alternative to dominant medical discourses (1970), to his rejection of what is core in psychoanalysis, its discourse of repression (1990).

His shifting stance, however, should not stand in the way of trying to articulate what we might, for want of a better term, call a "Foucaultian" – not just *Foucault's* - understanding of psychoanalytic practice and of its possibilities as a critical practice. A key challenge in doing so, however, is to resist the temptation to see problems everywhere, to see power swallowing up resistances against it at every turn. Foucault's rejection of normativity takes away the possibility of naïve utopian vision and equips us to comment on what is wrong with things the way they are; but it also leaves us limited when we want to say something about how things should or could be. And this is why we must remember Habermas, and why I have given his views so much space in this chapter. I suggest that Habermas is important, not because of the contents of his proposals regarding consensus-seeking, communicative action, and the ideal speech situation, but because of his very demand that we have something to say about what is good, about what we should strive for. In this sense, even if one disagrees fundamentally with his take on power and societal processes, and even if his views are held in parentheses at times, his work can be respected as the "shadow" - as a kind of other - of an increasingly popular strategic and conflict based view of social interaction associated with the work of Foucault (Flyvbjerg, 2000). To this end, I have tried to keep Habermas in the frame, and used Falzon to fashion more of a Foucaultian than Habermasian view of critical action in relation to which psychoanalysis might be examined, or examine itself.

In the process, I have inadvertently proposed a normative condition as a goal, the dialogical power relation, drawing from but ultimately replacing Habermas' own normative proposal of an ideal speech situation. Such an interaction in the context of clinical psychoanalysis is perhaps exemplified, though with some limitations, by Ferenczi's mutual analysis. Here, the analyst might approach hearing the other as other; not always positioned as an analysand (which Ferenczi mostly succeeded at), and perhaps not even as a psychoanalytic subject (which he did not), but as a dialogic participant whose resistances convey something about that otherness, and whose local knowledges are respected at least insofar as they are given room to be articulated and possibly even to be productive of its own effects. This does not mean participants need to reach consensus on the issues, but merely that their differences are heard, respected in the sense of being given space for elaboration on their own terms, and then reflected upon in those terms. For example, could these emergent discourses be juxtaposed alongside, rather than analysed in terms of, a psychoanalytic interpretation? Of course, there is still a structural power inequality, and the primary positions of analyst and analysand will continue to influence proceedings in favour of the former's discourses. Perhaps that inequality can be spoken of more plainly with the client, in terms of how we believe persuasion can work in clinical settings and in order to note patterns of influence, without routine recourse to transference and countertransference explanations. And then there is also the question of whether an attitude of openness and respect makes systematically different demands on analyst and analysand. After all, an analysand approaching the relationship in that way is far more vulnerable than is the analyst to having that intention dashed; the former's approach is more of a suggestion requiring the analyst's approval (as is clear in Ferenczi's case). It does not have a shaping force, but only a suggestive one, to use the terms suggested

in chapter 3, and hence only has the force of a question. The analysand does not have the culturally recognised entitlement to demand or expect such an interaction without having that expectation analysed, whereas the analyst's expectation of this kind of relationship is invested with more interactive authority.

Respecting the analysand's resistance means respecting him or her as other; and this in turn means adopting a reflexively responsive stance. These are interrelated critical functions, following on from each other. But if it matters that the analyst avoids inadvertently supporting, even if simply by being "neutral", political strategies of which one might not approve (the client's politics may be objectionable to a particular analyst), it is necessary to reflect on one's own politics; about how we want the world to be, or how we want it not to be. Taking a stand means being better positioned to respond, firstly, to particular politically salient issues on which one has taken a position and which seem relevant to the analysand's situation, and secondly, to the politics, resistances and critiques that matter to the analysand. The point is that the psychoanalyst is inevitably a political participant, and potentially functions, deliberately or unwittingly, to conscript his or her analysands into reifying, supporting, bypassing or challenging particular cultural discursive practices. If we accept this point, then it becomes imperative that this participation is clarified. If it is not, can psychoanalysts trust psychoanalysis to do the right thing?

In order to work towards these critical goals, we need to note the possibility that psychoanalysis might be inclined to make perhaps the most important mistake that Habermas made, but which he seems to have correctly noted in many of its practices: at least implicitly, it seems to see its critical potentials lying in its capacity to be "prior" to the forms of power that it addresses. Such conceptualisation does not promote a critical psychoanalysis, but rather accidental critique in the context of psychoanalysis' spreading across the political spectrum. An uncommitted psychoanalysis is vulnerable to incorporation into existing systems of power, into "blocs" of commitments that are not in themselves psychoanalytic. From those denied locations it can then be used to either critical or conformist effect.

But recognition of its internal location with respect to power may require a more committed-strategic than truth-focused orientation. This would involve not a suppression of its diversity in the quest for a true psychoanalysis, but an embracing of its inherent flexibility so that it can be aimed in a variety of clinically emergent critical directions. While its concepts might condition and limit its responsivity to power dynamics, psychoanalysis' strategic polyvalence is already in evidence: there is already a wide range of "psychoanalyses". It seems pointless though to engage in arguments about which versions of psychoanalysis are distorted, unscientific, or embody inadequate countertransference analysis (the argument most used to account for some of its conformist aspects [Frosh, 1987]). The attempted correction of such factors cannot guarantee critique, and so they cannot adequately account for psychoanalytic conformism. Rather, psychoanalysis' politically divided nature is evidence of its capacity for alteration, for diverse theorising and practice, and therefore at least in principle – and perhaps paradoxically - for critique. Thus, a critical psychoanalysis might involve a similar proliferation of ideas and practices to that already witnessed through the twentieth century: no longer, however, in the form of dispersal across the political

divide, but geared specifically towards making resistances salient on the one hand, and questioning power on the other.

Psychoanalysis is important because it is probably the most powerful tool available for thickening accounts of subjectivity. Its depth orientation has the potential to allow for a thorough grounding of a client's sense of identity in a way that integrates it fundamentally with the social and political domains. It is partly for this reason that the analyst's political inclinations and interests should be closely examined, not in order to remove them from the encounter, but to question the extent to which they should transparently inform it. Perhaps it is via such transparent commitment that the psychoanalyst could move a little more towards being the "participant" - rather than the authority figure - that Habermas wants him or her to be: but a strategic-communicative rather than a purely communicative participant; in a dialogical field of power relations rather than in an ideal speech situation. This might go some way towards deepening what it means for the client to give consent, and what it means for psychoanalysis to be critical.

7.7. References

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CHAPTER EIGHT
NARRATIVE THERAPY AND THE POSSIBILITY OF CRITICAL THERAPEUTIC PRACTICE[8]

8.1. Introduction

This chapter follows on from chapter 7 by examining further the relationship between therapeutic practices and sociocultural and political systems of domination. The particular case of narrative therapy will be discussed, and attention will be given to the relationship between the micro level of therapeutic practice and the macro level of societal networks of power. The following question guides this chapter: Are local, within-therapy practices capable of stimulating effective resistances against culturally dominant discourses and practices? In the previous chapter, three main obstacles to a critical psychoanalytic practice were explored: the difficulties associated with paying attention to resistance and with respecting local knowledge; with taking a political stand; and with demonstrating reflexive responsivity. Because narrative therapy orients more or less explicitly around Foucaultian concepts of power/knowledge, resistance, and the insurrection of subjugated knowledges, one might expect some of these challenges to be more easily met than seems the case for psychoanalysis. But difficulties remain even in this instance. This chapter will consider some of the power-related challenges facing a form of therapy that overtly advocates sensitivity and responsivity to power-resistance dynamics, conceived in more political than psychological or psychoanalytic terms.

As already noted, many practitioners of diverse theoretical orientations are critical of therapy's participation in the cultural network, and seek to promote what will be referred to as "therapies of resistance": approaches that not only privilege client rather than expert accounts, but that also render salient the situation of persons and their problems with respect to macro relations of domination, and promote political critique and even activism (e.g., Ali, 2002; Albee, 2000; Chaplin, 1999; Gilligan, Rogers & Tolman, 1991; Kaye, 1999; Newman & Holzman, 1997). Narrative therapy is one such therapy of resistance (e.g., Madigan & Goldner, 1998; Monk and Gehart, 2003; Nylund, 2002; Nylund & Ceske, 1997; Nylund & Corsiglia, 1996; Swann, 1999; White & Epston, 1990) that aims to use micro therapeutic procedures to effect or participate in macro changes. The importance of this approach is underscored by its emphasis on the central concepts of power and resistance that have pervaded the discussion in previous chapters. However, even in this case there are difficulties in attempting to launch political resistances from within the therapeutic domain. Despite numerous claims to therapy's politicisation, we have much to be concerned about regarding therapy's potentials - and the potentials of therapists and clients in the name of therapy - to perform protest to the extent that dominant discourses, practices and institutions are modified as a consequence.

I shall begin by using the concept of power to formulate the micro-macro relation. The political significance of therapeutic exercises of power (and client

[8] Chapter based on: Guilfoyle, M. (2005). From therapeutic power to resistance? Therapy and cultural hegemony. *Theory & Psychology, 15* (1), 101-124.

resistances against these) is frequently obscured from view in therapeutic work. In response, four ideas will be offered to make therapeutic power operations visible in a way that eventually reveals their engagement with the broader cultural and institutional domain: power as a productive force (and associated distinction between power and its effects); power's integration with knowledge; the relationship between power and resistance; and power as a contextual phenomenon. While these issues were discussed in chapter 1, here I develop those arguments, drawing on material from the intervening chapters. Narrative therapy as critical practice will then be considered in terms of these ideas.

Again, at numerous points this argument draws on the formulations of Foucault (e.g., 1980, 1982, 1990), whose views have been used to highlight problems of power in a variety of mental health fields: in nursing (e.g., Clinton & Hazelton, 2002), social work (e.g., Foote & Frank, 1999), psychiatry (e.g., Ali, 2002), and in the cross-disciplinary practices of psychotherapy (most notably in narrative therapy - e.g., Flaskas & Humphreys, 1993; Swann, 1999; White & Epston, 1990). However, there is no single Foucaultian approach to power, or indeed to therapy, and his ideas tend to be used, as he intended, more in the manner of a "tool kit" of ideas than as a coherent theoretical account. Further limiting theoretical consistency is the fact that his work was at times inconsistent and contradictory (Fish, 1999; Hindess, 1996), especially regarding the relationship between power on the one hand, and knowledge, resistance and the person on the other (the key issues to be considered below). However, given that my intention is to construct a coherent theoretical account of therapeutic practice's participation in the broader context, Foucault's particular conceptual inconsistencies will be subverted and I shall draw more from his later than earlier work.

8.2. Power and therapeutic practice

In this section, I propose four primary conceptual tools to facilitate the visibility of typically unseen or unrecognised procedures and mechanisms of power in therapy, in a manner that highlights their contextual relevance.

8.2.1. A positive account of power

This argument rests on Foucault's "positive" account of power; as a generative or productive, rather than repressive force. In Foucault's (1982) words, power "induces, it seduces, it makes easier and more difficult" (p. 220): power *does things* in the social world. This view enables an analytic separation of power from its effects. It means that we are able to consider therapeutic practice, if we take it as a bloc of knowledge/practice, as an effect of power, but also, to the extent that it involves exercises of power, as itself productive of effects. Therapy has been institutionalised as a legitimate and enduring cultural practice, integrated into networks of other institutionalised practices (e.g., medical, mental health, child protection and legal systems). As therapy is supported and maintained by its participation in these and other networks, it may be considered an effect of power. But it is also itself productive of effects; of discourses, practices, subjects and further power relations that become part of the broader cultural network.

This point of departure diverges from accounts of power commonly (but not universally) espoused in the therapeutic domain: power as the local and immediate influence or control of one person over another (e.g., Anderson & Goolishian, 1990; Golann, 1988; Kuyken, 1999; Minuchin, 1994 – as discussed in chapter 1). The power-effects distinction permits the conceptual separation of these visible processes - of influence, control, hierarchy and persuasion - from the processes of power itself. As noted in chapter 1, these processes may be evidence of the workings of power, they may be its products or expression points, and they may operate as vehicles or conduits of power to reproduce particular relationship patterns and associated knowledge forms, but they do not constitute power, and should not be conflated with it.

In other words, many therapeutic debates on power manage to circumnavigate the issue of power itself, and focus instead on only a localised and select portion of its most visible products. This limitation of what power can mean – as a between-persons phenomenon, and as overt and self-evident acts of influence – effectively limits the kinds of questions that can be asked of therapeutic work. It conceals a host of power-related therapeutic phenomena that do not appear, at first glance, to be practices of power, such as the constitution of the therapeutic relationship itself (see especially chapters 3 and 5), the therapeutic requirement of meaning-making (or the "incitement to discourse" – c.f., Foucault, 1990; see chapter 2), acts of knowing or interpretation, and even clients' resistances (these issues will be elaborated below). But also, and significantly, as noted in chapter 6, it shields the therapeutic institution as a whole from critique, drawing attention away from the forms of power we have in common, in favour of attention to the differences *between* therapies in terms of their sensitivities to the ethics of one person influencing another.

8.2.2. Power, knowledge and the production of subject positions

From the perspective of therapeutic practice, knowledge is one of the most important products and vehicles of power (c.f., Foucault, 1980). Power in itself is not a substance. It remains powerless and only a "virtual" reality if it is not given shape or empirical form (Deleuze, 1988). But in binding with knowledge or discourse, power can become actualised, given a direction, a method, and a rationale for its existence and functioning. Significantly, knowledge delineates objects on which power is able to operate, although knowledge continues to guide its operations, specifying what it can or cannot do, and constructing particular meaning out of its exercise. Power thus derives "targets": those objects delineated by discourse to be shaped by power in accordance with discursive expectations and prescriptions. In this way, the exercise of power may be transformed into, and come to appear as an exercise of knowledge, or truth; power is thereby reproduced.

It would be overly simplistic to say that clients are power's targets while therapists are its agents. (Hook [2003] suggests that therapists are more "officers" or "relays" rather than "agents" of power.) The therapist cannot invent and does not own power, since the therapist category – the institutionalised position he or she adopts – is already itself a product of power. It is a position that derives its meaning in the context of certain historical and cultural

arrangements, in accordance with which prescriptions and expectations are imposed on the person installed into that position. But the production of the therapist must be seen alongside that subject's positioning as an active and selective applicator of therapeutic knowledge: the ability to adapt and personalise interventions is definitive of therapeutic expertise. In other words, the therapist is a product and vehicle of power, but is also able to choose, within the limits of that position's professional and cultural requirements, how power is deployed. Likewise, clients are not passive targets, but also participate in their becoming known, and are in turn capable of resisting therapeutic ways of knowing.

It will be evident by now (from this discussion and from previous chapters) that therapeutic knowledge includes, but means more than the interpretive frameworks constructed or invoked within sessions. It also signifies a knowledge that precedes in-session applications of therapeutic theories and techniques. Specifically, therapeutic knowledge "tells" therapists and clients how to arrange their relationship, as a condition, and in preparation, for the appropriate deployment of theoretical and case-specific knowing. As I argued in chapter 3, a number of cultural discursive factors – such as the western construction of persons as self-contained and "interiorised" individuals (Rose, 1998; Sampson, 1993), the conflation of common-sense and therapeutic discourse (Parker, 1999), the elevated cultural status of "truth telling" professionals, and therapy's privileged standing as a way of knowing about persons and resolving their problems – mean that clients typically know more or less about therapeutic clienthood before even entering into therapy. This facilitates a process whereby therapeutic participants can be immediately interpellated into the therapist and client subject positions (although therapists might try to fine tune these positions in accordance with specific theoretical requirements). The therapist and client positions condition what occurs in their interaction by shaping and specifying the behavioural freedoms each party has in relation to the other. A distinctive therapeutic apparatus is thereby created, comprising (1) an expert applicator of knowledge, (2) an object of knowledge, and therefore (3) an appropriate direction for knowledge. It is in terms of this apparatus that each person's conduct relative to the other is organised, and power is given a (contestable) pathway through which to produce its effects.

These positions (which in chapters 2 and 3 I referred to as primary positions) produce a confluence of observational activity, which establishes joint – though sometimes conflictual - participation in an intense and relentless incitement to discourse, in terms of which the client undergoes a process of becoming known, both to the therapist and him- or herself. The client's instantiation in the position of clienthood renders him or her more or less malleable, as one to be invested with meaning, to be discursively shaped, the object and potential subject of particular ways of knowing.

These positions are omnipresent, stable, and irreversible in a therapeutic relation; they are institutional requirements for professional therapeutic practice.[9]

[9] It should be noted that attempts have been made to reverse the therapist-client positions with the aim of equalising power. For example, as discussed in the previous chapter, psychoanalyst Sandor Ferenczi attempted a "mutual analysis" with some of his clients. The point here is that, in accordance with the structuration of that relationship as discussed in chapter 3, one would expect the therapist, rather than the client, to make a final decision on, and lend overarching meanings to, such a course of action.

While this may seem an obvious point, claims to the democratisation of therapy (e.g., Anderson, 1997, 2001; Bird, 1994; Carpenter, 1994; Hoffman, 1988, 1992) frequently downplay its significance (Proctor, 2002; see also chapter 6), in favour of attention to what goes on *within* therapy. By remaining "within the therapeutic text" – by studying the *secondary* subject positions and power relations constructed in therapy talk - it becomes possible to misconstrue therapy as "just two people talking". In a successfully democratised relationship, people are able to freely invoke discourses, and hence are able to move between subject positions in fluid and dynamic fashion. In such an instance, while power is not removed, people are able to move between being power's subjects and its operators (Falzon, 1998). If we analyse the therapeutic interaction purely from within the text, such freedoms may seem evident for both parties.

But, as seems evident from the discussions of chapters 2, 3 and 6 in particular, therapy does not involve such a relationship. The discursive and positioning freedoms of both parties are governed by the overarching positions of therapist and clienthood to which they must in one way or another conform. Thus, as narrative therapist Michael White (in Hoyt & Combs, 1996) notes, therapy cannot attain democratic status. Regardless of what happens within therapy, it is necessary at all times for both parties to recognise who they are in relation to each other: who is the therapist and who is the client. Restrictions are inevitably produced about who can behave in what ways. When we consider power through the lens of what therapists and clients actually say and do, it is vital to also consider the positions from which this saying and doing emerges. In other words, therapeutic relating involves a form of "micro-sovereignty" (Hook, 2003), and its operation requires and produces an ordered and reliable regime of subject positionings. Thus, the meaning of any talk, and its ability to produce effects, are in an important sense governed by the principal and definitive subject positions of therapist and client.

These considerations - of therapist as applicator of therapeutic discourse, and client as knowledge object, in the context of a relationship focused on generating meaning about any and all aspects of the client's experience (subject to the therapist's preferred ways of working) - enable a view of these two subject positions as constituting a stable pathway for power. It is along this channel of meaning-making activity – from therapist to client; and also from client to client through self-examination, in the witnessing presence of the therapist – that specific discourses may be transmitted, to have shaping effects on the client's conduct and subjectivity (Hook, 2001; see also chapter 5). The application of therapeutic knowledge may therefore be characterised as vectorized in nature: having both direction and force.

Nevertheless, despite their culturally prescribed and distinct orientations within the encounter, neither therapists nor clients are passive bodies doomed to be shaped in accordance with the prescriptions of power and knowledge. Resistance is always possible. On the one hand, therapists have some choice about how to use their position as power's relay, and on the other hand, clients are able to refuse the interpretations applied to them.

8.2.3. Power and resistance

In this section, I focus on the client's resistance against therapeutic power. Therapists' resistances against being positioned as power's representative will be discussed below in terms of the contextual discourses and practices implicated by his or her resistance.

In the therapeutic literature, and has been noted previously, a client's resistance tends not to feature as an issue when power is discussed; and when resistance is examined, its relationship with power is typically ignored. This is perhaps surprising considering the obvious fact that people often resist being subjected to power. I have noted the tendency in the therapeutic disciplines to consider resistance in terms of therapeutic discourse – typically in individualised and psychological ways - which obscures from view resistance's more political dimensions. However, it should be noted that some authors attend to interpersonal aspects of resistance (e.g., Anderson, 1997; Arkowitz, 2002).

I have suggested that a minimal, but definitive, requirement of resistance is that the client says "no," or refuses to conform to some suggestion, interpretation or line of enquiry proposed by the therapist (c.f., Foucault, 1997). It can be developed beyond that point, as shall be discussed below with specific reference to narrative therapy, but a refusal of some sort is the defining starting point for all resistances. A client's "no", in the context of therapy, could be interpreted in numerous ways. Therapists are able to draw from any number of flexible, situation-specific and context-sensitive interpretive repertoires in response to client resistance. I have noted in chapter 1 that it may be seen as "behavioural noncompliance" (Newman, 2002), ambivalence about change (Arkowitz, 2002; see also chapter 2), internal conflicts (Wachtel, 1982; see also chapter 7), or a therapists failure to follow the client's lead (Anderson, 1997). Furthermore, as noted in the interviews with therapists in chapter 2, client resistance could be used as a pointer to problematic aspects of the therapeutic relationship, or as an indication of the client's avoidance of or non-readiness to explore "real" issues.

For most authors in the therapeutic arena, resistance does not seem to refer in any meaningful and attention-worthy manner to a power relationship. Not only is it almost inevitably given some form of meaning – as noted in chapter 2 – under the relentless incitement to discourse characteristic of therapeutic encounters, but it tends to be invested with *specific sorts* of meanings that minimise our vision of the power relationship to which it must inevitably refer. It is rarely acknowledged as an indicator of power.

But if we fail to acknowledge the inextricability of the resistance-power relationship, then we not only risk retaining a one-dimensional (psychological, internal) view of resistance, but we also risk missing a prime opportunity to discover where power is at work. Resistance is the key methodological indicator of power. The often obvious and observationally salient nature of resistance contrasts with the (at least) partially hidden operations of power; but the additional suggestion that they must co-exist thereby extends to us a methodological invitation. Resistance makes power empirically accessible to analysis, since it points us precisely to power's application points (see chapters 2, 4 and 6 in particular, for applications of this idea).

The problem for resistance, and the knowledges to which it may be tied, is that it is typically less productive of effects than is the power/knowledge complex against which it is oriented. A client's resistance is a relatively weak force, since it not only runs counter to the vectorized knowing process that flows along the pathway of power constructed by and for the therapeutic relationship, but it also opposes the cultural expectation that therapists know what is best. Any counter discourse(s) associated with an act of resistance, which may initially not be elaborated beyond blunt refusal (Foucault, 1997), is therefore relatively easy to dismiss or transform, and may thereby be rendered serviceable to the power it opposes. In the terms used in chapter 3, knowledges associated with resistance often have as-yet-undecided meanings, and their association with the client position makes them continually vulnerable to reinterpretation. Simply put, it is far more difficult for a client to effectively challenge a therapist than vice versa. But augmenting the effect of these formal subject positions, therapists are also trained to employ a range of interpretive strategies to neutralise a client's challenges (as noted above, and examined at length in chapters 2 and 5). Therapeutic knowledge provides therapists with such totalising ways of knowing that a client's resistance need never have transforming effects of its own, other than the mobilisation of techniques for its suppression, capture and transformation in the service of power/knowledge. And while client resistance may be respected in some instances, it is notable that its ability to shape therapeutic proceedings, and to produce alternative knowledges that survive and develop in the therapeutic encounter, is in large part determined by the therapist.

When we encounter resistance from a client it is instructive to consider what aspect of power is being opposed: Does resistance challenge the legitimacy of the professionally and culturally accepted pathway through which knowledge is passed? Does it challenge the therapist's legitimacy as a knower? And/or does it challenge the actual discourses used to understand the client's experiences? These questions, which specifically tie resistance to power, are obscured from view as we focus on what resistance might mean in terms of therapeutic discourses, or as we quickly move on to consider how it might be "overcome". These latter courses of action merely conceal the power relations and techniques to which resistance refers, and against which it is oriented. They dissuade us from sufficiently considering how our assumption of entitlements to "overcome" the client's resistance has been legitimised in the first place. On this account, expert knowledge (e.g., therapeutic justifications of promotions of insight) is in itself an insufficient justification for an overcoming or subjectification of the client that would in other social interactions with an "equal" be considered disrespectful, inappropriate and unacceptable (c.f., chapter 2).

Resistance is capable of exposing power. But psychological or therapeutic interpretation can undermine its ability to function as critique. Nevertheless, many therapists – most notably in the narrative therapeutic tradition - aim to respect client resistance, in a manner consistent with Foucault's (1980) call for the "insurrection of subjugated knowledges" (p. 81): local ways of knowing that may motivate or be motivated by resistance. This may involve the therapist's "joining" with the client's subtle allusions, or overt references, to protest (e.g., Freedman & Combs, 1996; White & Epston, 1993). These resistances may relate to intra-therapeutic processes, such as the therapist's assumption of entitlements to

know, and the positioning of the client as lacking in self-knowledge. But just as power can be located in a contextual domain, so resistance in therapy can refer to more than local contestations of meaning. It can point to extra-therapeutic processes, which may sometimes find their way into the consulting room, such as: the way in which problems are named and constituted (e.g., as psychological rather than social in nature); cultural prescriptions regarding identity (e.g., in terms of mental-health status, age, class, race, gender, etc.); and other power relations in which the client is disadvantageously positioned.

Attempts to respect resistances - allowing them to remain alien to therapeutic discourse (c.f., Falzon, 1998) – are made explicit in the theories and practices of narrative therapy (e.g., Monk & Gehart, 2003; Swann, 1999; White & Epston, 1990). This approach is notable not only for its attention to local power and resistance dynamics, but also for its interest in the relationship between these dynamics and macro, extra-therapeutic processes. Narrative therapy permits the posing of certain key questions: With which culturally available discourses, institutions and practices is power or resistance aligned, or into which of these are they capable of becoming integrated? And, conversely, against which discourses, institutions and practices is resistance able to position itself? In other words, we are taken outside of the therapeutic relationship itself, to question how our practices participate in the macro domain. Equally, the therapeutic privileging of the client's account is associated – unlike the prioritising of the client's voice in person-centred (Proctor, 2002) and collaborative therapies (e.g., Anderson, 1997) - with a deliberate attempt to situate that person's experiences in critical relation to culturally prevalent discourses and practices of power and resistance (Monk & Gehart, 2003)[10]. For example, the client's local knowledge and the resistances (against the problem, the therapist, or ways of knowing) implicated in this knowledge, may be simultaneously seen as potential challenges to subjectifying but culturally valued "internalising discourses" (Epston, 1993), which name and discursively organise the problem in prescriptive interiorising ways.

In narrative therapy, client resistance is given a broader brief than in most other therapies: not only can the client legitimately resist the therapist and his or her knowing, but this resistance may also in the process be made relevant – mainly as opposition – to any of a variety of circulating and culturally available discourses. The insurrection of local, ordinary knowledge may also lead to the integration of resistance with other disqualified knowledges, such as externalised or feminist ways of knowing (e.g., Swann, 1999; and as discussed in chapter 5), or through the establishment of communities organised to counter the effects of dominant discourses on persons' lives (e.g., Freedman & Combs, 1996). Thus, a client's resistance becomes not merely a local contestation of meaning, but an aspect of cultural practice. It is theorised that the knowledges linked with protest may therefore become "part of the common store from which people can choose" (Foote & Frank, 1999, p. 181).

[10] It must be noted that narrative therapists do not always discuss their politicised formulations with clients. Rather, these ideas are often used to orient the therapist's questioning rather than as ways of knowing overtly offered to the client (Freedman & Combs, 1996; Monk & Gehart, 2003).

8.2.4. Power's location: the problem of context

Narrative therapy highlights power's contextual nature. On the other hand, as noted above, the conflation of power and resistance with their effects predisposes to a local formulation of these processes that do not attend to their proper context. And when this context is ignored, it becomes seemingly reasonable to suggest that attempted democratised therapeutic practices can successfully dispense with the problem of power, or at least with its most obvious troublesome effects (e.g., Anderson & Goolishian, 1990; Bird, 1994; Carpenter, 1994). But on such accounts, power means no more than one person controlling another; it does not explicitly refer to matters of context. Also, the extent of critique that resistance can offer becomes circumscribed. For example, collaborative therapist Anderson (1997) states that the presence of client resistance is indicative of therapist failure. Such localisation of resistance, even though it may involve the privileging of clients' over therapists' views, precludes recognition of its possible relation to macro, extra-therapeutic processes. Similarly, those formulations that accept the therapist-client power imbalance (e.g., Haley, 1976; Minuchin, 1992), and which only problematize actions considered "abuses" of power (e.g., Aveline, 1996; Kuyken, 1999) effectively circumscribe and localise the meaning of power and resistance. They do not permit analyses of how power becomes available in a therapeutic encounter in the first place, and they restrict our view of what social or cultural knowledges are used to justify or rationalise power's deployment in that setting.

Power operations are so contextually embedded that its overall strategies and techniques are easily overlooked when we discuss its deployment in any local interaction (e.g., in therapy) without considering the broader network of power relations in which that interaction is itself embedded. Therapeutic power is significantly shaped by macro processes, including social, cultural, discursive and institutional forces (Hare-Mustin, 1994; White & Epston, 1990; Swann, 1999) and must therefore be considered in terms of their location within the entire "diagram" of power (Deleuze, 1988). To reiterate, therapy is merely one of power's "ultimate destinations" (Foucault, 1980, p. 96).

But this reference to "ultimate destinations" may mislead. It does not mean that power moves unidirectionally, emanating from the outside to be finally, and without further consequence, expressed on the inside. I mean rather that the inside (i.e., within therapy) is where therapeutic power/knowledge can be exercised in the most legitimized, authoritative, intimate, economical and efficient manner: focused exclusively, by an expert therapist *and* the non-expert client, on the client. Here, as outlined above and in chapter 3, power finds a culturally sanctioned apparatus and a well-prepared pathway, designed to facilitate the shaping up of the client and his or her problems. But it does not mean that this is where power "ends".

Therapeutic discourses in general, and therapeutic practices in particular, are not merely products or effects of the sociocultural context, but actively participate in the constitution of that context. They are part of a set of culturally available discourses and practices (which Ingleby [1985] calls the "psy complex") that produce and circulate particular accounts of what it means to be a person. For example, therapeutic ways of knowing inform and lend specific shape to such

cultural practices as parenting, teaching, relationships, industrial relations, as well as aspects of medical, legal and political practice (Burman, 1996; Cloud, 1999; Rose, 1998). They participate in the construction of ideals and standards of personhood (e.g., Parker, 1999; Sampson, 1993), delineate terms for the constitution, recognition and resolution of so-called personal problems, and specify places and appropriate subject positions for the expert and personalized application of these knowledges.

This process of "feeding back" into the culture introduces the possibility – as advocated by narrative and other politicized therapies - that therapeutic practice need not necessarily be serviceable to prevailing contextual institutions, discourses and practices; theoretically, it could critique and challenge these forms of domination. The therapist could refuse to operate as a relay point for power, and opt instead to function as an agent of resistance, seeking to convert the pathway cleared by therapeutic subject positions into an arena for the exploration of resistance. And while there is a paradox in the therapist facilitating a discourse of resistance against the very power/knowledge complex than supports the authority of the position from which she or he speaks in the first instance, the subversion of therapy's promotion of the sociocultural order is the expressed goal of certain therapists.

Thus we arrive at a key question: To what extent is therapy able to generate and provide an effective counter-discourse? Is it capable of challenging taken-for-granted ways of knowing and doing to the extent that it participates – perhaps, as Laclau and Mouffe (1985) might suggest, in concert with other resistances - in the construction of alternative, less discriminatory and more power-sensitive sociocultural arrangements? Let us consider for a moment some of the means by which therapeutically derived and/or promoted resistance can enter into the broader culture: therapists may offer critical formulations in journals, case conferences, and other discussions; clients may display and circulate resistance in their words and actions outside of therapy; and critical therapeutic knowledges may be circulated in the culture, for example, in popular and scholarly writings, in public and professional talks, in the training of therapists, and through their impact on the practices of others. A therapy of resistance can only have productive and transformative effects in the sociocultural realm to the extent that it is circulated – without being significantly mutated - beyond the immediacy of the therapist-client encounter.

The challenge faced here is one of promoting the circulation of counter-discourses while simultaneously protecting them from taming transformations. The danger is that they become subsumed by more widely accepted and circulated knowledges and practices: by prevailing institutions and orders of truth. As noted with respect to psychoanalysis in chapter 7, critical knowledges can become attached to a wide variety of societally available political objectives, and thus become "politically spread". In order to understand and potentially counter this process, it is important to explore "the manner in which they [i.e., discourses of resistance] are invested and annexed by more global phenomena and the subtle fashion in which more general powers or economic interests are able to engage with these technologies" (Foucault, 1980, p. 99). And so Foucault points to the challenge to be faced in establishing as a goal – as a measure of therapeutic or sociopolitical "success" – the upgrading of marginalized or

disqualified counter-discourses to cultural availability through therapeutic activity (as suggested by Foote and Frank [1999]): these insurgent knowledges remain vulnerable to neutralization to the extent that they must engage with those hegemonic discourses and practices that suppressed or disqualified them in the first instance. They must face power.

Narrative therapists recognize aspects of this possibility in work with clients. Therapy talk therefore involves "thickening" the client's story, which helps to strengthen alternative (i.e., therapeutically stimulated non-internalized) accounts, lending them an elastic applicability and performativity, which thereby affords some protection against appropriation. Story thickening may involve the construction of communities and "audiences" (Freedman & Combs, 1996), outside of the consulting room, which function to support and circulate these new local knowledges. These steps work to counter the appropriating potentials of knowledges and power relations with which the client may become engaged outside of the therapeutic encounter. But at a broader level, therapies of resistance such as narrative therapy – as blocs of knowledge/practice – are themselves also at risk of annexation. Such appropriation would not only limit their potentials for political transformation, but may even render them serviceable to the discourses and practices they oppose.

For example, while Monk and Gehart (2003) see narrative therapists as "sociopolitical activists," this approach is increasingly being used to support and advance – in technical and "pragmatic" fashion – a variety of therapies that do not share its political agenda. Consider, for example, March and Mulle's (1998) use of the narrative externalisation technique in their cognitive-behavioural treatment manual for childhood "obsessive compulsive disorder"; and Lieb and Kanofsky's (2003) use of narrative concepts and techniques in psychodynamic practice, to provide "corrective experiences" (p. 198) for "unconscious … pathogenic beliefs" (p. 189). This is not to say that such integrations use narrative therapy "incorrectly," but that under a discourse of therapeutic pragmatism (e.g., Amundson, 2001; Lieb & Kanofsky, 2003), the politically critical dimensions of narrative therapy are easily obscured and subverted. As it becomes more popular, narrative therapy is increasingly at risk of being *circulated as* just another set of techniques, and may in certain contexts (e.g., in the increasingly "scientific" domain of clinical psychology) begin to be judged according to its ability to empirically demonstrate (decidedly expert-oriented and individualised) "therapeutic efficacy" or "effectiveness". This would threaten to obscure the specific contributions that narrative (and other critical) therapies can make – or which they intend to make - to the broader culture.

At this macro level, narrative therapy (like feminist therapy as discussed in chapter 5) is located rather differently in the network of mental health and associated (e.g., insurance, medical, legal) relations than are other more individualised approaches, which advocate expert ways of knowing, behavioural values and norms consistent with self-contained individualism, empirically demonstrable symptom-resolution, in the context of assessments and interventions that may be structured around (or are at least consistent with) psychiatrically oriented diagnostic categories: the sorts of factors that promote a "goodness of fit" with the existing mental health and related context. The latter approaches are therefore more easily assimilated, *without undue transformation*,

into prevailing structures, and thus contribute to the reproduction of existing power relations. On the other hand, critical knowledges that emerge from politicised (rather than individualising) therapeutic sources are vulnerable to transformation as they engage with larger hegemonic systems. Thus, as it is with the client, it is important to recognise that therapies of resistance such as narrative therapy represent only a weak force in relation to existing sociocultural pathways of power. Consequently, and again as with the client, knowledges tied to these approaches become vulnerable to transformation and political dispersion. In this light, making therapeutic discourses of resistance "part of the common store from which people can choose" (as argued by Foote and Frank [1999, p. 181]) becomes a very difficult task.

The products of therapeutically derived discourses of resistance, and I have offered here the example of narrative therapy, may not necessarily end up challenging the institutions, discourses and practices they seek to oppose. Indeed, they may inadvertently contribute techniques and ideas to an already individualised therapeutic institution. There is the risk that they might "mean," to the majority of therapists, referrers, trainees and trainers, and perhaps even to clients, something rather different than resistance, political critique and sociopolitical activism. As long as they are identified as "therapies" they remain vulnerable to being constructed as just another set of ideas and techniques for the resolution of personal problems.

8.3. Re-examining therapy as resistance

This attempt to situate therapeutic practice in strategic relation to existing networks of power leads to the question of how to take matters forward. Many questions may be asked, but I will use the issues raised thus far to focus on two questions that I consider to be of central significance. Firstly, given that resistance tends to be a relatively weak force in relation to institutionalised power arrangements, and given its consequent vulnerability to transformation in the service of power, what steps can be taken to enhance its circulation, and hence its recognizability and productivity? And secondly, given the inequality embedded in the therapist and client positions, is the therapeutic relationship an ethically viable place from which to encourage resistance?

8.3.1. Towards productive therapeutic resistances

If a therapy of resistance is to be effective and transformative in the macro domain, it is important that we explore methods for its consolidation. Resistances, and the knowledges that support and are supported by them, need to become sturdy enough to withstand attempts at neutralisation and transformation (their psychoanalytic capture was discussed in chapter 7). This section offers a brief outline of how we might work towards this goal.

If resistance is a response to power, then to the extent that power is organised through and concentrated into institutionalised forms, many different resistances are likely to have as a *shared* point of reference the same, or mutually integrated, operations of power. For example, in narrative therapy, it is often assumed that a client's resistance challenges (or can challenge) a single cultural

type of power operation: the discursive location of problems inside persons. But it is equally clear that these resistances are not constructed in identical ways. This means that on the one hand, power can be tackled from numerous sources, and from a variety of knowledge perspectives: resistance is "transversal" (Foucault, 1982). But on the other hand, it also means that, especially when specific power operations are not widely recognised, resistances often lack mutual organisation and mutual reference: they are easily split off from each other, and may thereby be rendered relatively impotent.

Certainly, with respect to macro power arrangements, there are numerous divergent resistances that emanate from the therapeutic domain. Narrative practitioners are not the only therapists concerned with resisting dominant ways of knowing and doing, and self-declared feminist therapists are not the only ones interested in challenging patriarchal systems. Many others, speaking with reference to therapeutic and mental health systems from a variety of perspectives, have articulated the need for political and cultural resistance (e.g., Albee, 2000; Dineen, 1999; Kaye, 1999; Kutchins & Kirk, 1999; Newman & Holzman, 1997; Rustin, 2005; Smail, 1987; Sue & Sue, 2002). The problem, however, is that these resistances are more or less split off from each other. And it is significant that this owes more to the salience of their respective theoretical formulations in interpreting power (there is little joining up across theoretical boundaries), than to their inability to agree on which power arrangements need changing.

According to Foucault (1990), "it is doubtless the strategic codification of… [these multiple] points of resistance that makes a revolution possible" (p. 96). But it seems that the solution to the isolation of resistances is not the adoption of a singular integrated theoretical approach (or codification), since the proliferation of therapeutic knowledges – and of discourses of resistance – makes such unification unlikely. And if it were successful, it would subvert the tolerance of difference and respect for plurality that define therapeutic oppositions to hegemony.

However, it may be possible to deliberately use this transversality; to adopt it as a strategy, rather than to operate within it as a divisive circumstance. Thus, we may forge trans-theoretical alliances based on the mutual recognition of *specific sites and focal points of power*, rather than on agreed ways of interpreting them. Inspired by this recognition (as articulated by Foucault [1982]), Macleod and Durrheim (2002) make a similar suggestion for the variety of feminisms. They highlight the possibility of (in their case, feminist) "alliances of shifting points of resistance around concentrations of power" (p. 55). Thus, therapists do not need to adhere to any specific way of knowing (e.g., narrative, feminist, discursive, psychoanalytic, multicultural or constructionist theories) to recognise the significance of certain power related problems, such as: therapeutic procedures of normalisation; the control exerted by mental health policies and practices on the population, or on specified sectors of the community; the pathologization of clients; person and family blaming; the decontextualization of problems; or even the effect of government policies on self and other understanding (c.f., Rustin, 2005). Furthermore, concerns have been articulated about received gender- and power-obscuring formulations of so-called psychiatric or psychological problems such as "eating disorders," "depression," "borderline personalities," and "attention-deficit-disorders," from a range of perspectives

(e.g., Fallon, Katzman & Wooley, 1994; Kutchins & Kirk, 1999; Nylund & Corsiglia, 1996; Stoppard, 1999; Swann, 1999; Wirth-Cauchon, 2001). The fact that many have already critically discussed these processes is precisely the point: the need for resistance *is* widely recognised, although probably more in relation to specific power operations (e.g., the obfuscation of gender), than in relation to global and relatively intangible practices (e.g., therapy's cultural institutionalisation). And so this specificity (of power's focal points) can be utilised in the deliberate coordination of a transversal strategy of resistance. What is required is not theoretical consistency or integration, but agreement on specific concentrations of power against which a diversity and multiplicity of resistances should be raised.

An overt alliance of "strange bedfellows" might more effectively circulate, throughout the therapeutic and mental health fields (e.g., in therapist training, conferences, journal articles, books and book titles), the notion and significance of resistance as an ethical practice. Isolated articulations of resistance from *within* specific perspectives merely facilitates their minimisation as issues of concern, as critique is attributed to localised and therefore easily ignored theoretical sources (e.g., feminist or narrative therapy), or even to specific, easily disqualified "trouble-making" therapists or authors. In order to be productive of effects robust enough to resist neutralisation, therapeutic resistance should actively utilise rather than subvert its transversal nature. Different resistance formulations and tactics may be mutually respected – at least in moments of resistance - as precariously equivalent (Laclau & Mouffe, 1985) so that differences become "a resource around which to establish multiple points of resistance to the myriad of micro- and macro-level … relations of inequality and domination" (Macleod & Durrheim, 2002, p. 55).

The problem of the appropriation of therapies of resistance by more individualised, de-contextualising and power-obscuring approaches now takes on a different gloss. Under the guidance of a transversal strategy, the problem is not that a particular approach has been used in a way that subverts the resistances it could potentially pose, but simply that the annexing therapist has utilised his or her primary subject position to support certain specific problematic ways of knowing and doing (e.g., the psychologization or individualisation of eating disorders, and the related obfuscation of sociocultural processes of power and gender). It is what the therapy is doing in terms of its effects in the cultural context that assumes critical significance, regardless of which approach has been appropriated, and indeed regardless of whether appropriation has occurred at all. This is significant because it invites *all* therapists who are (for example) interested in challenging the therapeutically (as well as psychologically, psychiatrically and medically) common decontextualization of eating disorders, and not merely those from within the specific subsumed approach, to critique that therapy's participation in broader networks of power. Thus, while we might challenge *as* narrative, feminist, discursive or psychoanalytic therapists in certain instances, we are also simultaneously supported by, and supportive of, a conglomeration not only of therapists of different orientations concerned with those specific politically significant issues, but also of a range of other persons who are already demonstrating their resistance.

Certainly such an approach would be complex in many respects. The diversity of struggles joined against particular concentrations of power would probably be less than solidly constituted (c.f., Laclau & Mouffe, 1985), they would be vulnerable to in-house power relations, and they would rely on a tolerance of the different languages (a trait for which the therapeutic industry is not well known) that may be invoked for the purposes of critique. The requirement that the measurement of these struggles by their effects (e.g., the successful circulation of contextualised and gender-sensitive notions of eating disorders into common sense discourse) should supersede partisan concerns may temper differences of opinion, but certainly there are tensions to be faced.

What such a strategy does not attend to, and may even initially render invisible, is the possible dissolution of the therapeutic institution as a whole. Surely this should be our long-term, if idealistic, goal in any case: the production of a society in which professionalized therapeutic interventions no longer seem so necessary. But therapy's dissolution may reasonably be called for precisely for the opposite reason: that we are contributing to a society in which professionalized interventions seem *increasingly* necessary. It is in light of this latter possibility that the strategy of transversal resistance is suggested. It has become a matter of urgency that therapy displays, even proves, its relevance to social justice and to the challenging of hegemonic practices, and not just to the shaping and resolution of problems in atomised and context obscuring ways. The point is that we do not yet know, despite numerous implicit and explicit claims in the affirmative, whether therapy can stimulate resistance to the extent of social and cultural transformation (which may or may not involve its own termination). If it cannot, then the charge that therapy is a form of psychological and social policing will become increasingly difficult to deny. And so this transversal approach is proposed simultaneously as a method for challenging networks of domination, and as a means for beginning to answer that question.

But if resistance is to be undertaken ethically, as both a macro *and* a micro strategy, it is necessary to supplement the above mentioned macro strategies with an engagement with the problem of the therapeutic power relationship itself.

8.3.2. Local ethics and resistance

We need to take seriously the position in which we (as therapists) are situated, relative to the client, and from which we promote resistance. The pathway of power established in and for that relationship is not eroded by our (or our clients') protests against our respective subject positions. Therapists' refusals of the expert position in which they are installed does not prevent them from *being positioned*, in a way that they themselves cannot easily or convincingly alter (Carpenter, 1994; Golann, 1988; Young, Saunders, Prentice, Macri-Riseley, Fitch & Pati-Tasca, 1997), as expert knowers, both by clients and by the wider cultural network. As argued above, interactions that occur in a therapeutic relationship are governed by the principle positions of therapist and client, which fix the power relation in important ways. This means that the therapist's "honouring" of a client's resistance as a protest against practices of power (Foote & Frank, 1999) must itself be seen in the context of this power relation.

Thus, we may ask questions, initiate externalising conversations, and take stands on certain issues, but always *from a position of authority*. We operate with a certain kind of knowledge – for instance, of cultural critique, resistance, power and, perhaps, externalisation - but which relies for its persuasiveness on our position within the very cultural power systems to which we are opposed; on those systems that allow us to speak with authority – even as we contrive to speak against the position from which we speak. And so the insurrection of client knowledge *in therapy* is not only political in the sense that it challenges the subjugation of local ways of knowing. It is also a political act of more ethical significance for the therapist, insofar as the therapist utilises his or her position, within the intimate, vectorized, intensely client-focused, knowledge producing therapeutic space, to persuade persons of their strategic location within broader relations of domination: to know themselves in one way rather than another. This is mirrored by Rustin's (2005) implication that clinical psychoanalysis can serve as a tool to politicise the personal, as discussed in chapter 7. This is not the insurrection of local knowledge, but may be more accurately described as "covert political re-education" (Kitzinger and Perkins, 1993, p. 99).

In other words, the discursive relocation of a client's resistance does not occur without its *interpretation*. Under the narrative framework, resistance becomes an object of knowledge, to be known in terms of a critical and strategically situated discourse. This form of resistance – as politically rather than merely personally or therapeutically meaningful - is, typically, not in the order of a discovery, but should be seen as actively constructed in talk between therapist and client: in the client's talk with an authority figure. As narrative practitioners acknowledge, clients do not necessarily, prior to therapy's commencement, consider their problems as sociopolitically situated, but tend to view them precisely in the terms of dominant discourses. In other words, therapeutically derived resistance is not resistance "from the ground up"; it is more like advocacy and the promotion of resistance in the terms, and under the conditions, of a particular (e.g., narrative therapeutic) power/knowledge complex. Thus, we do not, in the benign manner of discovery suggested by Foote and Frank (1999), "unmask… power" and give "voice to marginalized experience" (p. 179); and it is obfuscating of power to suggest that these resistances, and the new ways of knowing associated with them, "seem to be… already there", in the client's talk (Freedman & Combs, 1996, p. 267). Discourses of resistance are not lying latent "within" the client, waiting to be drawn out by an expert knower. Rather, we *interpret* power, and thereby render marginalized experiences discursively salient.

These acts of interpretation also raise questions about narrative therapists' claims to "join" the client in challenging prevailing discourses and power relations (e.g., Freedman & Combs, 1996; White, in Hoyt & Combs, 1996; White & Epston, 1990). What sort of invitation do clients extend to therapists to justify such a joining? Typically, (again as recognised by narrative therapists) this invitation orients around the experience of "personal problems," rather than around clients' accounts of suppression or domination in the context of broader power relations. Thus, to the extent that therapists define the former in terms of the latter, the client's invitation is itself transformed, and imbued with more than its original meaning. "Joining with the client" in these instances is more accurately

understood as *the therapist's* persuasive invitation to the client to participate in macro-societal resistance.

None of this reduces my conviction that both our own and our clients' practices participate in – being constituted by and constitutive of – the macro sphere. Furthermore, this is not to say that we should *not* interpret therapeutic happenings, as well as clients and their problems, within a broader framework. Indeed, to operate without an interpretive framework – without a way of knowing the client and his or her life circumstances – and to remain solely within the client's (e.g., internalised) narrative, is to risk reproduction of the very discourses that led to the person's subjugation and the production of his or her problems in the first instance (Kaye, 1999). But as long as we promote resistance as therapists, we need to be exquisitely attuned to the possibility that the urge to resist might not come so much from our clients as from ourselves.

The only real solution to this was mentioned in chapter 7: for clients and referrers, as a condition of ethical tolerability, to be made aware of the therapist's political intentions, *prior* to the onset of therapy. Confounding this suggestion is the fact that narrative therapists, in particular, often do *not* actively pursue politicised meanings in actual conversation, but base their decision to do so on individual client presentations (Freedman & Combs, 1996; Monk & Gehart, 2003). The ethical problem here is that once that decision is made, the client is already a captive audience, and may already be subject to the power/knowledge complex represented and relayed by the (e.g., narrative) therapist. Given these concerns, we can only honestly claim transparency if our interest in a politicised and contextualised resistance is advertised. In so doing, potential clients are given room to consider *therapists'* invitations to participate in struggles against power before they decide to enter therapy; that is, to deliberate from subject positions external to the therapeutic power relation, which do not yet involve their constitution in the position of clienthood.

8.4. Conclusions

Perhaps the biggest advantage of a specifically therapeutic resistance, which also accounts for my hesitation in calling for the abandonment of therapeutic practice without first considering an energised effort at its politicisation, is that therapists are peculiarly and intimately located at the interstice of power and the person: at the place where it is possible to appreciate in some detail the subjugating effects of cultural hegemonic forms on the person. Certainly, it is precisely this location that makes us potential conduits and inadvertent representatives of power. At that juncture, we are tempted to know therapeutically, to conceal power, and to limit the resistances that threaten to reveal power. But, as long as the client is afforded the opportunity of prior choice, it is also a point at which power can be most intimately analysed, and from which resistances can be nurtured. However, the task of building a therapy of resistance is hampered rather than aided by its location within the broader therapeutic institution. I have argued that both micro and macro resistances – of the client within therapy; and of resisting therapies within the macro cultural sphere - are vulnerable to de-radicalising transformations upon engagement with extant systems and relations of power. And while some therapists (e.g., in the narrative tradition) may well attend to this

possibility in their work with clients, I suggest that we have not sufficiently considered the vulnerability to recuperation of our more macro oriented resistance methods and knowledges.

The advertising of therapy's politicisation, both with those involved at the level of local practice (e.g., clients and referrers), and with other therapists of a range of orientations (and indeed with practitioners of other knowledges and practices), under a strategic transversal rationality, and coordinated around specific hegemonic focal points, has been offered as simultaneously a means of more effectively circulating discourses of resistance, and of interrogating the feasibility of a therapeutically derived cultural resistance. We do not yet know to what extent our resistances can be productive at the macro level, but I suggest that we need to begin to find out.

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CHAPTER NINE
INTEGRATIVE SUMMARY AND DISCUSSION[11]

9.1. Introduction

The intention of this work has not been to provide a means for avoiding or equalising power relations in the therapeutic relationship. Instead, my aim has been to examine therapy's relationship with networks of power, so that it becomes difficult to take for granted - as a given, and as an apparently fixed background against which to analyse power - the claim that therapy works for the good of those who become its clients. I have tried, in the words of Foucault, "to show that things are not as self-evident as one believed, to see that what is accepted as self-evident will no longer be accepted as such" (1989, p. 154). This, for Foucault, is a key function of critique, and I have endeavoured to generate questions about the features of therapeutic relating and practice that are so easily taken for granted, and about the societal proliferation of therapeutic discourse and practice.

In this chapter I address the four orienting questions set out at the beginning of this thesis. In doing so I propose a diagrammatic account of therapy's situation with respect to the societal context of power relations, and suggest avenues for future research inquiry. I will then examine potential critiques of the studies that have been presented.

9.2. The four questions of this thesis

Four broad questions were identified in chapter 1:

- What forces impact on participants in the therapeutic encounter?
- How is power concealed in therapy?
- How might it be made visible?
- What is the relationship between therapeutic power and power operations at the societal-political level?

I will attempt to summarise some of the arguments and conclusions of the previous chapters in terms of their relevance to these questions. However, while these questions are distinguished to enable analytic clarity, the points raised in relation to them must be considered inextricably linked.

9.2.1. What forces impact on participants in the therapeutic encounter?

I do not aim here to provide a comprehensive list of intra-therapeutic forces, but will try to outline the ways in which forces are organised in therapeutic encounters, as discussed in previous chapters. I undertake this discussion in two parts: focus falls firstly on the forces that shape the relationship itself, and then on power's impact on the client's talk and self-understanding.

[11] Parts of this chapter based on: Guilfoyle, M. (in press). Power and the psychotherapeutic relationship. In A.M. Columbus (Ed.). *Advances in psychology research, Vol 48*. New York: Nova Science Publishers.

9.2.1.1. The therapeutic relational system

I have argued that therapy operates in and through an interaction-organising system (referred to as a "therapeutic relational apparatus" in chapter 3), in which participants are ascribed the primary and mutually exclusive positions of therapist and client. Immediately - before the more visible interpretive work of therapy gets under way – these positions themselves already provide for each person a discursive framework for the construction of meaning and action, and for understanding the actions of the other (as discussed especially in chapters 2, 3 and 8). These social categories function to regulate the circulation of power in the encounter. It is important to note, therefore, that the positions of therapist and client are not merely "roles". The idea of role playing obscures the functioning of power, and invites notions of participants as "equal but different", or as collaborators with complementary skill sets, mutually influencing each other (e.g., Corsini, 2000; Fruggeri, 1992; Weakland, 1993). Clearly, therapists and clients do influence each other, and they do bring different sets of skills to the interaction. But the primary positions set conditions for *how and how much* they can influence each other and for the deployment of their skills (as discussed in chapters 2 and 3). These positions distribute speech and action expectations and entitlements, and produce differentiated types of vulnerabilities.

For instance, the therapist is entitled to act in ways that might be considered intrusive and disrespectful in other, non-therapeutic settings (chapter 2). The client is vulnerable in the sense that therapists are allowed and sometimes expected to behave in ways that might counter the client's wishes. Indeed, the client's disapproval may sometimes be used as evidence for the validity of intervention. Further, therapists are free to choose therapeutic style, approach and interpretations in a way that the client is not (as noted in chapter 6). This is already an ethical problem in itself, and it can go on to have significant consequences, as evidenced in cases where therapists pathologize self-identified homosexual clients as theoretically justifiable enactments of their professional entitlements (see chapter 7).

I propose that the person installed in the therapist position is culturally invested with expertise and special knowledge and abilities, while the person in the client position is constructed as a knowable, malleable and deferring other. Of course, it is possible for participants to counteract these expectations, and I do not argue that they are evident in all instances. However, I suggest that contrary intentions are vulnerable to a series of forces both from within (e.g., the client's expectations) and from the outside of the relationship (e.g., in the guidelines of professional societies; in supervision; in the courts; in professional team meetings), designed to restore the encounter to its pre-constructed, culturally recognised shape.

This means, firstly, that any client's resistances against being known in particular ways, or against being positioned as a changeable and uncertain being, may be met with direct or indirect "corrective" forces, inside and outside of therapy; forces that persuade or encourage that person to adopt a more appropriate and therapeutically accessible client position. This was evident in the gradual transformation of Megan's self-talk in chapter 5, where she was subtly and indirectly encouraged, both inside and outside of the consulting room, to

understand herself and her eating behaviour in a way that would make her more recognisable as a therapy client, and hence more therapeutically accessible.

Secondly, any therapist's interest in opposing or subverting the culturally and professionally constructed form of therapeutic relationship must be weighed up against – and seen in the context of - the numerous intra- and extra-therapeutic voices that function to pull the interaction towards its culturally and professionally designated shape. Indeed, many therapists aim to distance themselves from the expert position. But, as discussed in chapter 6 with reference to the work of collaborative therapist Harlene Anderson, such distancing may require considerable in-session rhetorical work to move towards an alternative relational system. Putting aside for the moment the finding that clients of collaborative therapists tend to perceive their therapists as "expert" (e.g., Carpenter, 1994; Young, Sanders & Prentice et al, 1997), it seems that even within collaborative therapy, one person is powerfully pulled towards the expert knowing therapist position, and the other towards a knowable, malleable and deferring client position. As a counterweight to such pulling, Anderson continually provides the client with potential entry points for resistance – for alternative understandings - against her (Anderson's) own ideas and expert influence. She thereby tries to extricate herself and her client from the fixed culturally and professionally provided therapeutic relational system. But the point is that in the process she seems to recognise that the client is not as free as the therapist might like, or as a collaborative formulation of the relationship might predict, to create and perform resisting activity: the extrication is not easily realised. And so on the one hand Anderson speaks to the client *as if* they were already in collaboration, while on the other hand, and simultaneously, she tries implicitly but persistently to move that person *towards* a collaborative position. But this persistence - the need to have the therapist's talk infused with uncertainty (Anderson, 1997) through what I called "discursive uncertainty markers" – is revealing. Thus, the therapist's in-session collaborative efforts might to some extent undermine the pre-constructed therapeutic relational system, but the need for persistence also reveals its powerful and enduring influence on proceedings. It is perhaps paradoxical that Anderson's work ends up highlighting what she intends to oppose: the stubborn predispositions of the respective primary positions that invest one person with a persuasive and knowledgeable voice and situate the other in more uncertain and vulnerable fashion.

The primary positions of therapist and client may be considered relay points through which power passes to produce its therapeutic effects. Power is given empirical form in these positions. But as power, which emanates from extra-therapeutic, societal sources, is crystallised in the therapeutic relational configuration, it is also tailored in the process. It is distributed so that the voice of one holds more authority than the voice of the other; it is converted and delegated through common-sense and expert knowledges into a broad set of entitlements and vulnerabilities; and it is given discursively constructed objectives and objects through which to perform its transforming work.

9.2.1.2. Power and the shaping of the client

On the basis of these discussions, it is possible to hypothesise a four-stage sequence of forces that shape the client to make therapy a practicable endeavour (see figure 9.1).

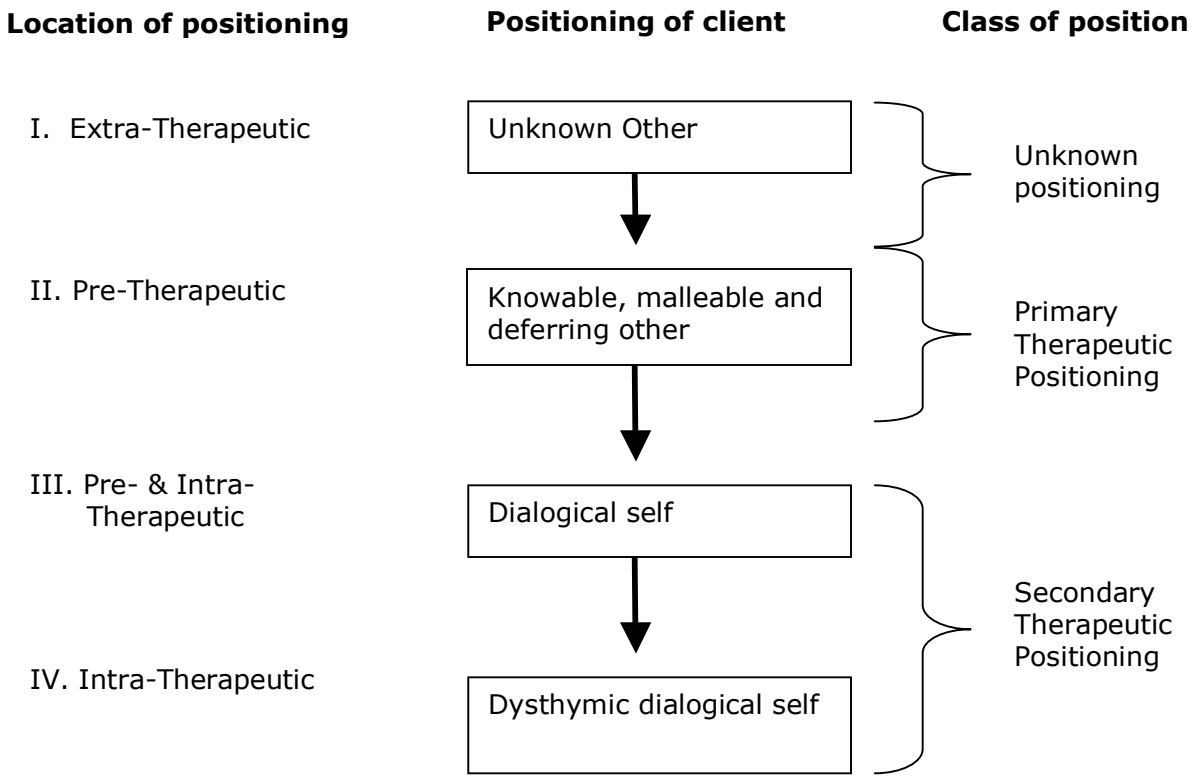

Figure 9.1.: The progressive therapeutic shaping of the client (using the example of dialogical self theory)

Initially, before entering into therapy, the person is an unknown other. This other lives, speaks and constructs meaning about his or her life in an extra-therapeutic space (stage I in figure 9.1.). Thus, she or he may be positioned in terms of any number of culturally available discourses, which may or may not be consistent with therapeutic discourses. But when that person is referred, or considers referral, to therapy a variety of discursive and material procedures are put in motion to install that person into the generic client position (stage II): as a knowable, malleable and deferring other. For example, questions arise at that early point, for referrers, for the potential client, and perhaps for his or her family and friends: What is the diagnosis, and what is the cause of the problem? What psychological issues and personality features are involved? How would a therapist interpret these issues? Such questions are further entrenched by media

representations and other common sense discourses of therapeutic practice and of problem categories (such as depression, low self esteem, eating disorders, and so on), which help circulate into the culture the sorts of understandings that enable persons to enter therapy in more or less appropriate manner. In other words, the person is primed - pre-therapeutically - to become known by therapeutic means; to open him or herself up to potentially new ways of knowing. And in such opening up, she or he is expected to demonstrate a degree of malleability, or willingness to change, and a willingness to be uncertain – to not-fully-know - about the meaning of his or her life circumstances (as discussed in chapter 3).

In the meantime, the designated therapist has his or her own knowledge predispositions, the development of which may have little to do with any particular client. In figure 9.1 I have drawn on the example of the therapist who, a priori, centralises the concept of the dialogical self (stage III), as discussed in chapter 3. Obviously this differs from therapist to therapist: before meeting the client, the psychoanalytic therapist already expects someone influenced by unconscious forces; the cognitive therapist expects that cognitive distortions will lie behind the problem; the feminist therapist expects to find a person influenced by gender prescriptions; the narrative therapist anticipates that problems will be tied up with cultural narratives; and so on. But at this level I also include other background knowledges of the therapist, which may emanate from any number of sources in the broader culture; for example, the notion of a self-contained individual, the idea that homosexuality is a deviant or perverse expression of sexuality, the idea that problems are caused or sustained by psychological processes rather than by social, cultural or economic conditions. Essentially, stage III client positioning refers to the deployment of a variety of therapeutic and other knowledge categories that are inherent in the discourses of particular therapists prior to the onset of any particular therapeutic encounter.

These pre-therapeutic background understandings of the therapist may not exert influence on the particular client prior to the onset of therapy; consider, for example, the client who has never heard of the dialogical self. But in some instances they might be influential before therapy begins. For example, the client may have wondered about unconscious influences and chosen to seek out a psychoanalytic therapist. It is important to note, as argued in chapter 3, that such a priori, pre-session knowing rests on the assumption that all clients are knowable, malleable and deferring or uncertain beings in the first place; beings capable of preparing themselves to become discursively captured in and by one or other set of therapeutic or associated knowledges (i.e., stage II is required if stage III processes are to be productive).

But if this general shaping of the client (e.g., as a dialogical self, a collaborator, or a self-contained individual [i.e., stage III]) does not always occur prior to therapy, it does occur at the intra-therapeutic level, as more intense and systematic procedures are put in place once therapy begins, to map out the contours of the person in terms of that specific a priori understanding. Even the collaborative therapist, such as Harlene Anderson (as discussed in chapter 6), who specifically positions the client as a dialogical participant, actively engages in activities to render salient and to bring forth into the interaction that person's collaborative or dialogical abilities. The person is considered malleable enough to forego any expectations of expertly crafted diagnoses, formulations and solutions,

and to arrange their conduct along collaborative lines. Similarly, the dialogical-self therapist may use questionnaires communicating an understanding of persons as multiple selves (e.g., Hermans & Hermans-Jansen, 2004). Or the therapist who understands certain eating behaviours in terms of psychological discourses might guide the conversation so that broadly psychological objects and ways of knowing are prioritised (chapter 5). The point is that in all these cases, the therapist works to produce his or her pre-therapeutic understandings of what a client is – or should be - into existence.

Then, extending beyond this broad understanding of clients in general – as self-contained individuals, collaborators, dialogical selves, and so on - and as therapy proceeds, more specific, personal and unique issues arise that permit more precise positioning (in stage IV). It is noteworthy that it is typically only at this point – the terminal point of a far broader set of shaping procedures – that the more observable, intra-textual and intra-therapeutic fashioning of talk and self-understanding occurs (the shaping of talk and subjectivity will be discussed below). Thus, for example, the person may become not only a dialogical self, but a specific *sort* of dialogical self, perhaps dominated by a dysthymic position (chapter 3); or the person might move from being a broadly psychological being at the beginning of therapy (stage III) to being a mutually recognisable bulimic with unique psychological difficulties (stage IV) (chapter 5); or from being a non-specific therapeutic knowledge object to one who is specifically avoidant, depressed or resistant (chapter 2); or from being inadequately self-contained towards displaying autonomy and enhanced self-determination through anger management (chapter 4); or from being a container of unconscious forces in principle, to one whose unconscious dynamics have promoted a misconstrual of one's political interest in the environment (chapter 7). It is notable that our attention is typically only focused on the second part of each of these formations in accounting for therapeutic happenings, as the first tends to operate in assumed and taken for granted ways.

The differentiation of primary and secondary positions is intended here merely as a heuristic device to highlight the point that, for the client, the achievement of unique, personal and sometimes fluid positions within therapy is largely conditional on the adoption of a generic, universal and pre-constructed therapeutic position. These positions represent relative crystallisations - increasingly refined relay points - of the successive layering of forces (through knowledge) on the person installed in the client position. In this way, that person becomes increasingly competent, and in increasingly nuanced and personalised ways, to represent and circulate therapeutic and therapeutically consistent discourses, and to counter alternatives (such as feminism, as discussed in chapter 5), both within and outside of therapy. The person is transformed from an unknown other into a competent representative of therapeutic discourse and practice. She or he thereby unwittingly becomes a "side-taking" political actor, capable of contributing to the reproduction of a society that privileges therapeutic and associated ideas and practices and undermines many of its competitors.

It should be noted that stages II, III and IV may sometimes be empirically and experientially contemporaneous. For instance, in the bulimia case of chapter 5, the client gradually became a therapeutically accessible client in a primary sense (stage II) *through* her secondary positioning by and into a psychological

discourse (stage III) that itself was operationalised via specific, personal therapeutic interpretations (stage IV). Nevertheless, despite this empirical overlap, the distinction between these stages can be analytically useful. With respect to that case, my own failure as therapist to recognise the workings of stage III – the client's transformation not into a bulimic being specifically, but into a self-recognising *psychological* subject more generally – hindered recognition of *non*-psychological or extra-therapeutic, discursive and positioning possibilities, such as those associated with feminist or local knowledges. Similarly, in the family therapy case of chapter 4, exclusive focus on Lionel's efforts to make changes (the key intra-textual, stage IV, interpretation of that case), or on the therapist's observable interventions in that regard, easily conceals the privileging of self-containment that facilitated the prioritisation of Lionel's individualism as the cause of change, rather than the effects of medication as suggested by his mother. The point is that while the stage III location of Lionel's conduct in a self-containment discourse on the one hand, and the therapist's stage IV attempt to persuade family members that he deserved credit for his efforts on the other, may have occurred simultaneously (e.g., see extract 4, chapter 4) it is nevertheless important to note their analytic distinction: the latter interpretation was made possible by the therapist's, and then the family's, invisible collusion with the western idealisation of self-containment, and the implicit disqualification of other possibilities. These analytic distinctions facilitate awareness of, and open up questions about, a wider network of forces that participate in the shaping up of the client and of his or her difficulties than might be immediately observable.

Let us turn briefly to consider the more specific, nuanced and personalised secondary positions themselves (stages III and IV). How do these become available? I have argued that these therapeutically produced positions can be made to seem real, practicable, relevant and personally resonant for the client through rhetorical or persuasive techniques. But if therapy is to be optimally effective the discourses in use and the positions they construct must also inform the client's subjectivity or sense of self. I will briefly consider each – rhetoric and subjectivity - in turn.

Through an analysis of rhetorical strategies (in chapter 4), I suggested that the therapist can use direct or covert forms of persuasion to achieve and reproduce particular accounts of problems and personhood. While a wide range of therapeutic approaches are available, it may be difficult for therapists to escape the contemporary western model of persons as self-contained individuals. To that extent, therapy practices in general might tend towards the reproduction and idealisation of western ideals of personhood. (This may be considered an example of the ways in which culturally dominant discourses enter into therapeutic practice, often in ways that are invisible and seemingly beyond question.) The point here is that therapy involves the use of rhetorical devices - such as ironisation and reification (see chapter 4), or conversational topic changes that subtly undermine client self-knowledge (see chapter 5) – to support certain accounts and destabilize others. It is noteworthy that accounts that are consistent with the original generic position offered to the client by the therapist (i.e., stage III in figure 9.1) tend to be supported. To paraphrase Foucault once again, the effectiveness of rhetorical strategies turns the therapist's preferred theoretical accounts into discourses that construct the realities of which they speak.

Rhetorical procedures may also contribute to the shaping up of the client's subjectivity or self-knowledge. This was discussed in chapter 5 with specific reference to the therapeutic production of what might be termed a psychologised-bulimic subjectivity. In that case the client was persuaded to understand her conduct and herself through the lens of a specifically psychological way of knowing. She began to construct self-narratives that increasingly centralised issues of body-image, self-esteem and eating behaviour, as well as a variety of internal psychological objects such as guilt and anger. It is notable that the client initially refused to construct her eating conduct in these terms, and she used more external than internal attributions to make sense of her behaviour. Over the course of therapy, however, she was gently persuaded to overcome her initial resistance, and in the process she became increasingly proficient in understanding herself and her conduct in more internal (i.e., psychologically consistent) ways. Thus, therapeutic operations of power work not only to facilitate forms of talk consistent with specific theoretical approaches, but may also promote identities or subjectivities through the construction of associated secondary subject positions.

Through the intended or unintended shaping up of talk and subjectivity, therapy produces a known, recognisable and discursively captured other. One of the most important functions of therapeutic power is that it not only produces objects that can be known in the terms of some theory or knowledge system, but *subjects who construct themselves* in ways consistent with these knowledge systems. The primary positions and their therapeutic arrangements may thus be considered powerful tools for the reproduction and refinement of certain culturally available ways of knowing and living, and for the undermining of others.

9.2.2. How is power concealed in therapy?

I have argued that power can be concealed in a variety of ways: through the conflation of power with its effects; through the salience of knowledge and related techniques; through the reconstruction of resistance; and through the decontextualised focus on local processes. In this section I will draw on the preceding studies in an attempt to elaborate on these techniques in more integrated manner.

9.2.2.1. Knowledge and a negative view of power

Therapeutic emphases on knowing, on the discovery of psychological truths, and even on finding solutions to resistances, simultaneously construct and render invisible pathways through which power can produce its effects. In chapter 2, therapist-interviewees - faced with a hypothetical case of disagreement between therapist and client regarding the latter's late arrivals for sessions - constructed a number of therapeutic discourses designed to enable an overcoming of the client's resistances. But such overcoming was not seen by participants as an exercise in persuasion, as a means of *producing* realities that support therapeutic change in particular and the therapeutic enterprise in general. Rather, they spoke of this overcoming as an exercise in helping, and as a way to discover psychological truth. One way of thinking about this difference is as follows: in response to the broad interview agenda (see section 2.3 in chapter 2), therapists were not

concerned with the question: "What gives us the right to marginalise the client's objections and persuade him to speak and understand himself in terms we find familiar?" Rather, they oriented much more around the question: "What is the real psychological reason behind his lateness, and how could we optimally pass on this understanding to him?" And yet it is significant that interviewees oriented around the first question, *and not the second*, in responding to an identical interaction taking place in a non-therapeutic setting (see section 2.4., analysis, of chapter 2). Thus, while the operation of power as a positive, productive force in the interaction is, in principle, to some extent visible it becomes obscured when the situation is interpreted as a therapeutic one. The generic therapeutic interpretation of the therapeutic scenario encouraged observers to overlook the exercise of power that was so clearly evident to them in the non-therapeutic scenario. In other words, while therapeutic knowledge becomes a pathway for power within therapy (e.g., by positioning therapist and client differently), it can also be used to render invisible its serviceability to power (e.g., by encouraging participants to ask only therapeutically related questions).

Observers' readings of, and participants' orientations to, the therapeutic situation are instances of power's concealment through knowledge. As noted in chapter 8, when it is stated that therapeutic knowledge conceals power, we must remember that knowledge refers not only to theoretical formulations, or to the ideas introduced in the actual encounter in the form of questions, statements, interpretations or other interventions, but must also include pre-session and culturally available knowledges about what therapy is, about what counts and what does not count as therapy, and about what it means to be a therapist and a client. Persons tend to orient to that encounter using particular knowledges rather than others, and those knowledges form a meaning-context for the intra-therapeutic generation of meaning, although they are not necessarily evident within the talk data itself.

One feature of these pre-therapeutic, orienting knowledges – following the study of chapter 2 - seems to be that therapy is a "helping" interaction structured through expertise, and not a power relationship involving the shaping up of talk: therapists do not shape persons, but understand and help them. This formulation, which is bound up in common-sense discourse (and also thereby helps structure the relationship as discussed above in section 9.2.1.), may have impacted on the interactions reported in the study of rhetorical strategies in the family therapy case of chapter 4. In that case, family members did not see changes as dialogically or discursively *produced*, but as related to the *discovery* of Lionel's "natural", once-hidden qualities of autonomy and self-composure. In other words, family member did not consider Lionel to have been actively shaped through knowledge applications into the more culturally desirable form of self-containment; rather his self-determination was seen as something *already lying within* him. Their pre-therapeutic knowledges of how therapy works – which I, as therapist, may have unwittingly reinforced during sessions – seemed to make it difficult to appreciate therapy's talk-conditioning and person-shaping aspects. These common-sense background knowledges may have prepared them (and me) to read the interaction in such a way that shaping operations of power are disguised through the apparently truth-unearthing operations of expert knowledge. Power is thereby obscured.

A final point on the concealment of power by knowledge: it is interesting to consider that professionals and laypersons may be most capable of recognising therapeutic techniques *as* power operations when they are deployed in *non*-therapeutic settings. When primary positions change, power's identity and recognizability also appears to change. In certain interactions (such as the business interaction in scenario 2 of chapter 2), the techniques of persuasion, interpretation, or confrontation are clearly visible as manipulations of, or attempts to shape, another's conduct: as exercises of power. But it seems that in therapy, similar conduct on the part of the therapist comes to mean something else. This differential orientation raises an important point. The popularity of a negative account of power might conceal its operations, as suggested by Foucault, but this does not mean that common sense knowers are blind to some of its positive (though often decontextualised) dimensions. These productive features are not, strictly speaking, invisible, as demonstrated by participants' responses to scenario 2 (of chapter 2). Therefore, it is suggested that analytic attention might be given not only to the concealing potentials of a negative view of power but also to our tendency to reinterpret its positive aspects through a partitioning of the social practice landscape in such a way that "power" (in the positive sense of a shaping force) and "therapeutic helping" are constructed as different sorts of activities. Perhaps one key task of the analyst of power is to reveal and disassemble our relatively fixed and categorical interpretive orientations to social action. This point is methodologically significant, and alludes to a set of techniques for the revelation of power, to be elaborated below.

This is not to deny that a negative view of power – such as Habermas' equation of power with repression and distortion - continues to operate and to hinder our appreciation of therapy's role in society- and person-building. Indeed, the dominant tendency in therapeutic practice is probably to consider new therapeutic meanings as discoveries or unearthings of latent personal qualities – or as stories that seem to be "already there", as suggested by narrative therapists Freedman and Combs (1996, p. 267) - rather than as products of discursive activity, as discussed in chapter 4. Such a formulation may betray an enduring commitment to a negative view of power, as a series of forces that prevented these qualities from emerging sooner; and to an idea of therapy as liberating these repressed or hidden aspects of self. This view facilitates an idealisation and a decontextualization of therapeutic practice, and a concealment of its own power techniques. But here I am simply emphasising that some of power's positive features are indeed noticeable, that they often seem distasteful and not a feature of good therapy, and therefore that they may easily be reconstructed so that they come to count not as strategies to shape up conduct in accordance with our discourses, but as efforts to discover the truth.

9.2.2.2. Reconstructing resistance

Psychological formulations of resistance are of course examples of the way in which knowledge conceals power. But I have chosen to separate this point from the previous one because reformulations of resistance not only hide power, but disarm and obscure the very force that threatens to make it visible. Resistances may be considered critiques of power that are often unacknowledged. But

because they are critiques, they are key strategic targets for power's operations. Thus, a common – implicit or explicit - therapeutic task is the conversion of resistance into an example of something other than the interpersonal conflict or disagreement to which it refers at face value. What it can become is limited only by the therapist's or client's abilities to create meaning. For example, it could become an example of transference or some other psychoanalytic process (as noted in chapter 7); of a client's avoidance or denial (chapters 2 and 5); or of a mother's failure to credit her son's efforts (chapter 4; see below). Through such translation, resistance becomes a supporting and vindicating example of the very therapeutic discourse it once explicitly or implicitly opposed. At the same time, resistance also becomes the reason why power – in its therapeutically mediated form – is needed in the first place. The exercises of power known as therapeutic intervention seem necessary precisely because persons are not always docile, and do not simply absorb themselves into pre-determined and prescribed therapeutic knowledge systems. In a therapeutic context, resistance becomes a justification for persuasion.

If therapy is to effect change, resistances need to be overcome and transformed (e.g., from an interpersonal to an intrapersonal phenomenon). The main strategy for overcoming a stubborn resistance is its absorption into a therapeutic or psychological meaning system: it becomes known in such a way that its ability to critique power is obscured from view. Thus, for therapist-interviewees discussing a client's argument with a therapist (scenario 1 in chapter 2), the most important issue was not the interpersonal dimension of the argument itself, but the psychological characteristics displayed by the client in the process: his fear of intimacy; his avoidance of certain issues; his lack of self-awareness; and so on. This shifting of attention from resistance's immediate interpersonal location is a powerful tool for the concealment of power. This is further evidenced in the family therapy case of chapter 4. In that case, Sharon (Lionel's mother) and I disagreed on the cause of Lionel's improved behaviour (see extract 4). The combination of her "medical" discourse and her account of Lionel as "naturally reasonable" could potentially serve as a critique of my own self-containment, "agentive" account of his behaviour, and thereby help reveal the power dynamics involved in our negotiation of meaning. Instead, through my interventions her talk became an example of how she failed to credit Lionel for his efforts (see especially the last turn of extract 4). In this way, Sharon's potentially resistant statements were resituated: away from their status as a legitimate alternative account of Lionel's behaviour offered in dialogue, and towards being a feature of her family's destructive dynamics. Her latent resistance could not reveal therapeutic operations of power because it was discursively removed from the power relation in which it emerged (between us) to "mean" something about her and her family.

The bulimia case of chapter 5 is interesting because no such overt translation of resistance is evident, despite the client's initial refusal to see her behaviour in therapeutically accessible ways. And yet if we pay attention to the primary structuration of the therapeutic system via its primary positions, it becomes apparent that broadly conceived therapeutic discourses were already in operation as therapy commenced. Merely by being a client, Megan already knew that she was being positioned by her parents, and probably by me, as one suffering from some form of psychological disturbance (see extract 2, chapter 5).

The content of the remaining sessions subtly supported these psychological views (although terms like "disturbed" did not feature in our conversations) to such an extent that Megan began to understand herself precisely in the terms from which she initially sought to distance herself. Through discussion of safer areas, she was gradually persuaded to give up her otherness (stage I in figure 9.1), to step into a more "appropriate" and recognisable client position (stage II), and her resistance was overcome; not directly but indirectly over time as she used the conversation to reconstruct her understanding of herself and her situation. She could then position herself in therapeutic discourse, which constructed her conduct as a psychological sort of issue (stage III), before coming to recognise herself as a psychologised bulimic (stage IV).

Power undermines and takes ownership of resistance in therapy not only through overt, observable therapist interpretations (such as in chapters 2 and 4), but also through a more subtle process of the interpellation of the other into the client position (as in the case of Megan in chapter 5). In the latter case it is then a relatively straightforward matter of re-interpreting that resistance at a later stage of therapy, although such active re-interpretation hardly seems necessary at that point. In other words, resistance can be overcome and power concealed not only through secondary processes of therapist persuasion, but also through a more primary process whose operations often begin prior to therapy, as the other becomes more client-like: knowable, malleable and uncertain. In both cases, the interpersonal and political meaning of resistance may be hidden as therapeutically consistent meanings emerge.

9.2.2.3. Context

I will defer discussion of *how* the societal context influences and is influenced by therapeutic discourse and practice (see section 9.2.4. below), since the current focus is on how power is concealed. Here, I consider some of the strategies through which therapy's location in an overall context of societal power relations is rendered invisible. There are both micro and macro reasons why this obfuscation is significant. At the micro level of understanding the therapist-client interaction, decontextualising strategies function to hide a significant portion of power dynamics and thereby facilitate a simplification and misunderstanding of therapeutic procedures of influence. And at the macro level of understanding therapy's relation to social, political and cultural practices, these techniques conceal therapy's participation in society building, its integration with culturally available strategies that support certain ways of living and undermine others, and its hidden conscription of clients into these strategies.

The breadth and extent of power operations can be hidden to the extent that focus falls only on empirically observable events between therapist and client. If we focus only on what occurs within the text, it becomes difficult to note the impact of extra-textual factors on observed events. I suggest that such an intra-textual view fosters idealisations of the therapeutic relationship as a person-to-person encounter. Such idealisation seems implicit in therapeutic work associated with Hermans' notion of the dialogical self (chapter 3) and in the collaborative language systems approach of Harlene Anderson (chapter 6). While it is difficult to argue against attempts at egalitarian relating without seeming to

de-humanise or reduce therapeutic participants, my point – as I have argued throughout this work – is that the therapist's *intentions* to work in egalitarian fashion cannot remove power from the interaction. However, these intentions may effectively conceal the forms of power that continue to operate. As noted in the discussion of Anderson's work in chapter 6, dialogue is peculiarly complicated in therapy. What appears as a dialogue of equals between therapist and client (e.g., extract 2 of chapter 6) displays characteristics that distinguish it from a dialogue between friends (e.g., extract 1 of chapter 6). It is significant here that if we study the therapeutic interaction in isolation, these characteristics are not easily noticed. And yet through a comparison with extract 1, it becomes apparent that there is something operating on the therapeutic interaction that Anderson – or indeed any therapist – cannot control, despite her intentions.

Paradoxically, given her democratic aims, it is the pervasive presence of power dynamics in that encounter that leads Anderson to continually employ special speaking techniques (of tentativeness and uncertainty) to ward off therapy's seemingly monologic leanings. The point is that therapeutic dialogue requires special techniques for its operation precisely because of the relationship shaping forces that emerge from the outside. There is a series of non-visible forces exerted on participants in a therapeutic situation, which persuade them to adopt the complementary positions of expert-knower and non-expert-known. This point was also discussed in relation to therapy associated with Herman's theory of the dialogical self (chapter 3), where I argued that forces both internal *and external* to the immediate encounter seem to pull the relationship in a more monological than dialogical direction.

The failure to attend to these external, contextual factors limits what can be understood about therapeutic operations of power, and makes it seem that the problem of power in therapy can be resolved merely by talking and acting differently. This narrow and local view of power focuses only on what I have termed power's secondary dimensions while overlooking the primary mechanisms through which power is channelled and through which participants speak to and hear each other. Such decontextualization thereby fosters a misunderstanding of how influence works in therapy and makes possible an idealisation of the encounter as simply two people talking.

Therapy's decontextualization can also be discursively achieved by therapeutic knowledges themselves. That is, the cultural and political factors associated with therapist communications (e.g., via assessment tools, therapeutic questions or interpretations) are themselves easily concealed by how we know. For instance, when I argued that Lionel should be given credit for his improved behaviour as an agentive and self-determining individual (in chapter 4), it was not apparent that I was supporting a specifically western account of the ideal person. Similarly, when I worked with Megan (in chapter 5) to create a psychological account of her eating behaviour, it was not immediately apparent that many alternative and culturally available ways of knowing and living were being subverted in the process (including feminist discourses and Megan's own extra- and pre-therapeutic understandings). In each of these cases, therapy's strategic location in the broader network of power relations – "taking sides" on such questions as what it means to be a person and how we should know ourselves – is

hidden. In this way, the knowledges we use can make it difficult to notice the ways in which therapy functions as a sociocultural and political force.

9.2.3. How can power in therapy be made visible?

In these studies, a variety of conceptual tools have been advanced to facilitate power's visibility in the therapeutic encounter: the distinction between primary and secondary positioning; the articulation of a therapeutic relational apparatus; the formulation of resistance as internal to power, or as always referring to its operation; the view of therapy talk as rhetorical in nature; and the shaping effects of knowledge in general. I will not explore these concepts any further at this point, since they have already been discussed at length. Instead, in this section I focus specifically on methodology; on the advancement of research tools for the detection and analysis of power. Three main, but interrelated, research strategies are discussed here: (1) the analysis of therapy talk as rhetoric, specifically in the terms of power and resistance; (2) the analysis of primary and secondary positioning; and (3) analysing talk for its potential alliance with culturally available discourses and practices and its deviation from others.

9.2.3.1. Therapy talk as rhetoric

Rhetorical analyses can be useful in identifying the dynamic movement of power and resistance in a therapeutic interaction, and thereby help prevent the development of a simplistically hierarchical view of power as one person controlling another, or as a force available to one participant rather than another. While the primary positions of therapist and client facilitate particular flows of power in the encounter, the actual talk can guide the way in which power moves leading to different conversational processes and outcomes. Rhetorical analyses serve as reminders both that power infuses all talk, and that while the primary therapeutic positions are relatively fixed, the operation of power is not. That is, the conversation is not predetermined, and there is possibly an infinite range of secondary positions that can be made available to participants, even from within the fixed relational terms of the formal therapeutic system.

One might use a rhetorical lens – analysing talk as a form of argumentation (c.f., Billig, 1996) - to explore both discourse and subject positioning dynamics. Firstly, it is possible to examine the dynamic arrangements of culturally available discourses within talk and to note how these discourses are used to manage each other. For instance, as noted in chapter 4, one discursive framework (e.g., the medical interpretation of Lionel's behaviour) does not necessarily disappear when it is criticised by the therapist, but may be retained in altered form through its placement within the more accepted framework.

And secondly, we can analyse these rhetorically deployed discourses in terms of the subject positions they make available (e.g., Parker, 1992). Discourse arrangement through overt or covert argumentation achieves a corresponding arrangement of subject positioning options. The discernment of these options might become a useful area of study in the therapeutic field, given that the visibility, salience and appeal of subject positions are likely significantly related to the processes and outcomes of in-session argumentation. We might then note

some of the following processes: certain positions come into focus as others recede from view; some become salient, practicable and immediately available, others become proximal but not immediately apparent, while others still become remote, for example being located within an alternative – perhaps disqualified – discourse, or on the boundaries of two intersecting discursive frameworks, from where they might even threaten an alteration of the discursive landscape; some positions may be subtly reconstituted in accordance with prevailing discursive trends, while others may be reified and discursively "thickened"; some may become more attractive while others become a sign of weakness, failure, or of some other less appealing "personal quality". Analyses of these processes as features of explicit or implicit therapeutic argumentation can facilitate a nuanced exploration of the ways in which participants understand and access options for being a person and for being in relationship with others, and clarify the power-resistance dynamics in therapy talk. In these ways it is possible to highlight the intra-textual complexities of a dialogue-with-power (Falzon, 1998).

However, rhetorical analyses do not specifically address the contextual conditions under which power becomes differentially available to participants. If we focus only on talk as argumentation, we cannot meaningfully attend to the conditioning effects of the context in which it takes place. It was therefore necessary in these studies to consider methodological means for moving beyond intra-textual rhetorical phenomena.

9.2.3.2. Analysing the power of primary positions

In an attempt to move beyond the text, while still paying attention to what goes on within it, I propose a technique for the analysis of the impact of primary positions on therapy talk. This technique, used in different ways in chapters 2, 3 and 5, might facilitate identification of aspects of the social ordering functions of institutionalised positions. While it is deconstructive in effect, it is abductive in design. Following Bateson (1972), the process of abduction involves the generation of a double description to enable a "depth" understanding of the phenomenon under investigation. As I have employed it, the abductive research process involves comparing two sets of talk data – a target text and a comparison text – allowing for at least a double description of the target text. By applying impressions and readings of the alternative text to the text under study, new possible readings and questions of the latter can be generated. It may then be possible to identify some of the less visible "social work" being done particularly by participants' primary positions, enabling understanding of the ways in which these positions discipline talk, create differential entitlements, and distribute access to different forms of power. Continuing with Bateson's metaphor, my goal with this method is to "deepen" our understanding, and extend the questions that can be asked, of the power mechanisms involved in the therapeutic situations under study. I will briefly consider each of the three examples of the analysis of primary positions used in this work, before commenting on their commonalities.

In chapter 2, I took a sample of talk between therapist and client and then gave them different primary positions: the therapist-client dialogue (scenario 1) thus became a dialogue between two colleagues (a therapist and a lawyer – scenario 2) whose primary task was writing a book. Therapist/research

participants were then asked to comment on these two scenarios. My aim as researcher was to alter the subject positions that I reasoned most observers would use to orient to, and to understand the meaning of, the respective situations. By doing so, I could identify not merely the tasks associated with different roles, but some of the things the scenario characters were given – or not given - permission to do, in accordance with their primary positioning. In that case, it became clear that the therapist could ask intrusive questions, persistently pursue a line of conversation she felt was important, and demand to know the psychological meaning of the other's conduct even when asked not to do so; but a business colleague was granted no such entitlements, and indeed seemed disrespectful when she engaged in identical activity. And yet without the latter comparison, it may have been difficult to appreciate the extent of the therapist's entitlements, and of the client's corresponding positioning as a knowable, malleable and deferring other.

In chapter 3, I took a sample of talk between therapist and a client complaining of dysthymia (extract 1) and simply reversed their primary positions (extract 2). While the previous strategy (of chapter 2) permitted an identification of therapist versus client entitlements, this position-reversal strategy generated questions regarding the formal organisation of their *relationship*. It must be noted that these talk samples were not used as part of a research strategy, but as illustrations of certain theoretical points raised, in part, by the findings of the study of the previous chapter. A richer analysis might have been generated had I interviewed persons about the two interactions.

Nevertheless, it seems that the meaning of the interaction changes significantly when positions are reversed (i.e., when the client sounds more like a therapist, and vice versa), in the sense that the telling of problems, or alternately the offering of interventions, mean something different when spoken by a client or a therapist. And yet the organisation of the relationship does not necessarily change in the process. Indeed, this comparative method allows formulation of the idea that the meaning of what is said - under such circumstances of position reversal - *has* to change if the pre-constructed organisation of the relationship is to remain intact. That is, if a therapist who sounds like a client is to remain a therapist in the interaction, it should be possible for those client-like actions to be reconstructed as *interventions* of one sort or another. And if a client who sounds like a therapist is to remain a client in the interaction, and thereby keep the structure of the therapeutic relationship intact, those therapist-like actions must be *interpretable* as the conduct of a knowable, malleable and deferring other. My interest here of course lies not in the dynamics of role-reversal per se, but in the capacity of the abductive role-reversal *method* to highlight and raise questions about (1) the relative fixedness or elasticity of the therapeutic relationship, (2) the relationship between meaning and relational structure, and (3) the relationship forces that enable and constrain the client's generation of meaning and secondary positioning options in therapy.

While the compared texts of chapter 3 were not employed in the manner of a research project, I suggest that the following questions might usefully guide the interview should such a task be undertaken: (Taking extract 1 as an interaction between therapist and client without specifying which is which) Who is the therapist and who is the client in extract 1, and why do you say this? What clues

do you have that lead you to this understanding? What if the situation were not as you expected, and we found that extract 2 (the role -reversal situation) is the actual therapeutic encounter? How might you explain the therapist's (client-like) conduct in extract 2; and the client's (therapist-like) conduct? What stands out as acceptable or unacceptable in either scenario? In a research project, one might ask these questions of therapists, of clients, and of laypersons not involved in therapy, in order to examine degrees of overlap between the views of these "categories" of persons, as well as possible points of difference. The point is that in the process, it may become possible to identify some of the social forces - which may at times run counter to each other - that act on persons who enter into a therapeutic relationship, either as therapist or client, and thereby refine or perhaps alter my proposals of the therapeutic relational system offered in that chapter and in chapter 8.

In my third attempt at an abductive design, in the chapter 6 examination of collaborative-dialogical therapy, I compared therapy talk data (extract 2) with talk between two friends (extract 1). This comparison differed from those of chapters 2 and 3, however, in that the actual talk data in the two scenarios differed. But in this case it was important to show differences in the *actual talk* itself; to show that there are ways of resisting power in ordinary dialogue that are not easily available to the client in a therapeutic situation. In that instance, I tried to show that the therapist (Harlene Anderson) had to continually *make the client aware* that resistance was permitted, and to *give the client space* to offer an alternative discourse if she chose to. Therapy seems to be inclined away from being a dialogue, if dialogue involves two people speaking freely and without constraint, when it is necessary for one of those persons to be continually given permission by the other to do so. Again, the comparison between texts was crucial. In this case, the comparison was designed so as to highlight what the client was *not* doing in the therapeutic interaction. An alternative description (to Anderson's collaborative-dialogical description) of the therapist-client conversation could thus be generated, in the sense that there seemed to be a mutually spontaneous quality, and fluid power-resistance dialogical dynamics, in the friendship scenario that was not evident in the therapy interaction. This new description highlighted something that seemed to be missing, and led to the generation of questions that Anderson's theory of therapeutic dialogue had not addressed. Specifically, the comparison text usefully demonstrated the overt presence of dialogical power-resistance dynamics against which the *apparent absence* of these dynamics in the target therapeutic text could be made conspicuous.

These three examples have at least four features in common. Firstly, they each involve a stepping outside of the immediate target text - the interaction we wish to understand - in order to show more about what goes on inside it. That is, they represent arguments for the idea – which runs counter to the suggestions of Potter and Wetherell's (1987) classic text - that we cannot be textually bound if we are to understand an interaction. Secondly, they each involve attempts to research and theorise the impact on the interaction of *forces* that come from the outside. Clearly, as demonstrated in all three instances of comparative method, the alternative text made salient at least the *existence* of such external forces, and thus helped raised new questions about the target interaction that observers might not have considered when reading that text in isolation. The third common

feature of these examples is that they each involve what may be termed a "manipulation" of primary positions. By changing these positions, it was possible to highlight aspects of the work that they perform in an interaction, and thus to identify some of the more or less fixed ways in which power works in therapy. It should be reiterated, as argued above in the discussion of the importance of rhetorical analyses, that therapy's relationally fixed dimensions do not exhaust power's operations, but may provide a framework through which participants understand the interaction, their own conduct, and that of the other. The manipulation of primary positions via comparative textual analysis might facilitate identification of some of the contours and functions of that power framework.

Finally, the fourth common feature is that each example of abductive comparison facilitated the generation of an alternative meaning-frame for – and hence a double description of - the text under scrutiny. In this regard, Shank (1998) has used the concept of abduction to propose a "Law of Juxtaposition". This law holds that the juxtaposing of one problem, process or event with another, which might not be remotely associated with the first, allows observers to step outside of their conceptual boundaries and produce new insights. A juxtapositioning – or abductive – methodology creates tensions between two (or more) possible accounts of some event or process. This tension in turn, according to both Bateson (1972) and Shank (1998), "calls out" for a third set (or more sets) of explanations, and thus has the capacity to generate new avenues for research. Thus, in the three examples presented in this work, the comparison texts were not used to impose interpretations on the target texts, but to raise questions about them; to generate meaning frameworks that would not exactly *replace* typically therapeutic interpretations, but alert us to issues that those latter interpretations seemed unable to raise for attention.

9.2.3.3. Integration with culturally available discourses

Finally, as suggested by Parker (1992), talk can be analysed in terms of its degree and type of consistency with culturally available discourses and practices. This was attempted most clearly in chapters 4 and 5. In the former case, talk was analysed in terms of its allegiance to the dominant western self-containment discourse; and in the latter case, in terms of its relevance to the discursive struggle between psychological-therapeutic discourses on the one hand, and extra-therapeutic feminist discourses on the other. I further suggested in chapters 7 and 8 that a client's (or indeed a therapist's) resistances might equally be examined with reference to its position in the broader discursive horizon.

Researching the integration of therapy talk with broader strategies may be usefully undertaken, at least initially, through a process of reflection on one's own therapeutic work. The link between local and cultural processes can thereby become clear in a more experiential than theoretical-abstract way, from which point it becomes easier to design research activities to explore these questions outside of the narrow confines of one's own professional practice. The benefits of exploring the micro-macro link through therapeutic experiences with which I was intimately familiar first became evident to me following my transcription of sessions from the case of bulimia described in chapter 5. It became clear early on as I began to study the dynamics of our in-session talk that my own words

seemed to have a subtle shaping effect on Megan's words over time. Questions arose in my reflections: What had happened to Megan's own understanding of her conduct? Why had I not really tried to understand her alternative views? Indeed, how could I have done so? I then started to feel troubled by the question of what was shaping my shaping of that talk. Which ways of knowing were guiding my own actions and speech? Clearly, I had to look outside of the locality of our (therapist-client) interaction and our words to begin to approach those questions.

Still more questions emerged, that would give me some direction regarding where to look in my quest to understand these extra-textual factors: If I was having a shaping effect on the talk, what other possible talk-shapes was I *not* using? Which knowledges were available to me that could be used to understand Megan's behaviour, but that I did not think - or feel free - to use? Was this a matter of my non-expertise on such ideas, or was it that I felt it somehow inappropriate for me, as a therapist, to introduce what may have been extra-therapeutic frameworks into the discussion? Immediately, the issue of eating disorders suggested gender as such an alternate meaning frame. Why, in my interactions with Megan, did I not speak very much, or very explicitly, about gender? And when gender issues did emerge, why did they seem always to recede almost imperceptibly into the background, and why did more familiar therapeutic and psychological understandings persistently come to the fore, both in my own formulating and in our discussions? Following such questions, a different sort of question became available to me. If I was in some way undermining – through non-expertise or some sense of therapeutic responsibility – feminist ways of knowing in this case, which ways of knowing and living was I supporting in my sessions with Megan? Indeed, to what extent had I consciously chosen to support these ways of knowing and living that I inadvertently represented, and did my subversion of alternatives sit comfortably with my political and ethical sensibilities? Indeed: What sort of social world was I siding with and helping to build?

Such reflection - which I also found essential in analysing the family therapy sessions reported in chapter 4 – enables a questioning of our position, not just as therapists who try to understand and resolve personal problems, but as co-authors of the cultural and political landscape in which we practice. We can also then pose questions about the political strategies that we invite our clients to either support or challenge through therapeutic meaning production. In undertaking such situated reflection, we may develop increased sensitivity to the dynamic relationship between local-therapeutic and macro-cultural processes. This would permit the formulation of research questions to be investigated through analyses of therapy cases (such as in chapters 4, 5 and 6), and/or via the construction of research designs to explore therapy's sociopolitical functions and situation.

For example, the excerpts offered to therapist-interviewees in chapter 2 might be usefully shown to a variety of others for comment. We might invite responses from persons associated with mental health professions, such as social workers, doctors, psychiatrists, nurses, and so on. Or we might ask therapists of different approaches. Or we could interview laypersons who have never attended therapy, past or current clients, or perhaps persons known to have alternative views on helping. Or one could ask interviewees to imagine the client to be

themselves, or their child, parent or partner; to generate specific observing positions from which to orient to the situation. We might then use the data generated to pose some of the following questions:

- In interviewees' talk, what discursive supports are extended to the therapist on the one hand and the client on the other?
- From which speaking positions do these forms of support emerge, and are there noticeable patterns in this regard? For instance, is there a systematic difference between the interpretations of interviewees who are mental health professionals and those positioned as the client's loved ones? Or between narrative and psychoanalytic therapist interviewees? If there is - or is not - a noticeable difference, why might that be the case?
- Which of this array of client- or therapist-supports are most easily articulated; and by whom? Which are more difficult to express; and for whom?
- Which of these discourses and associated subject positions can – or probably cannot - be reasonably accessed by therapists; or by clients?
- Which subversive options are culturally available for clients or for therapists (in the talk of interviewees), and how accessible are they?

A wide variety of questions can be researched to help clarify the intersection between therapeutic discourses on the one hand, and discourses circulating at a macro, societal level on the other. By posing the specific series of questions proposed here, which significantly orient around an extract displaying a local discursive struggle within therapy, we might make a number of advances, such as: (1) gain increased understanding of the range of client positioning options that are in principle available (some of which may seem inappropriate in therapy, or might simply not have been considered); (2) refine questions about possible pressures that support or prevent the adoption of some positions rather than others; (3) situate particular approaches with respect to the discursive horizon – as developed via a wide interview base – and to compare such location with that of other approaches; and (4) notice those discourses and positioning options that seem either disruptive to, or supportive of, this or that kind of therapeutic approach, and thereby move towards clarifying the political dispositions of these approaches.

All of the discourses generated in talk (through interviews) should be considered ways of knowing that are available within the societal discursive landscape. And so if we had access such a wide range of discourses, generated via interviewees with diversely positioned persons, we could construct an approximation of a cultural-discursive horizon *within which* it may be possible to find some of therapy's discursive and positioning "places". For example, we might locate the ideas generated *by therapists* (such as in the study of chapter 2) within the range of discourses produced via interviews with persons speaking from a range of extra-therapeutic positions; to situate the local-therapeutic discursive struggles (as exemplified in the arguments depicted in the text that interviewees are asked to respond to) within the strategic discursive relations evident within the macro-societal domain. Of course, there can be no comprehensive "gathering" of extra-therapeutic discursive resources, but it is nevertheless important to find

ways of researching therapy's location amongst available ways of knowing and doing, and thereby to discover more about the "social work" that therapy does.

9.2.4. What is the relationship between therapeutic power and power operations at the societal level?

This section is undertaken in three parts. Firstly, I tentatively propose a diagram to clarify my proposals regarding the relationship between local therapeutic relating and societal power arrangements; secondly, I employ that diagrammatic mapping of power to discuss the possibilities of therapy challenging these arrangements; and thirdly, I discuss some cautions for interpreting the proposed model.

9.2.4.1. Mapping local-therapeutic practices within societal networks of power

I propose a diagram of power (see figure 9.2) to prompt debate and suggest avenues for research enquiry. The arrows depict the trajectories of power and resistance, and each block (labelled A to F) represents relay points of power, which are simultaneously (1) processes that lend shape to those that follow, and (2) products of the processes which preceded them. I will briefly summarise the processes depicted in figure 9.2 before focusing in more detail on some of the diagram's key suggestions.

The category of culturally available discursive resources (A) refers simply to the societal store of discourses that are available for use. It is the starting point of power, in the sense that strategic relations of power are given form by discursive withdrawals from this overall context; and it is also the product of power, in the sense that the processes and outcomes of these strategic relations make some discourses more available and accessible to enculturated persons than others.

This societal accumulation of ways of knowing is given some degree of order via strategic discursive struggles (B). In the process standards of truth emerge (C), which produce institutionalised and widely accepted relations of power by crystallising and entrenching subject-positioning options for social participants. For our purposes here, societally accepted truths might include the notion of the person as a self-contained and psychological individual, and the idea that personal problems are knowable via expert applications of therapeutic knowledges that orient specifically around such psychological and self-contained processes.

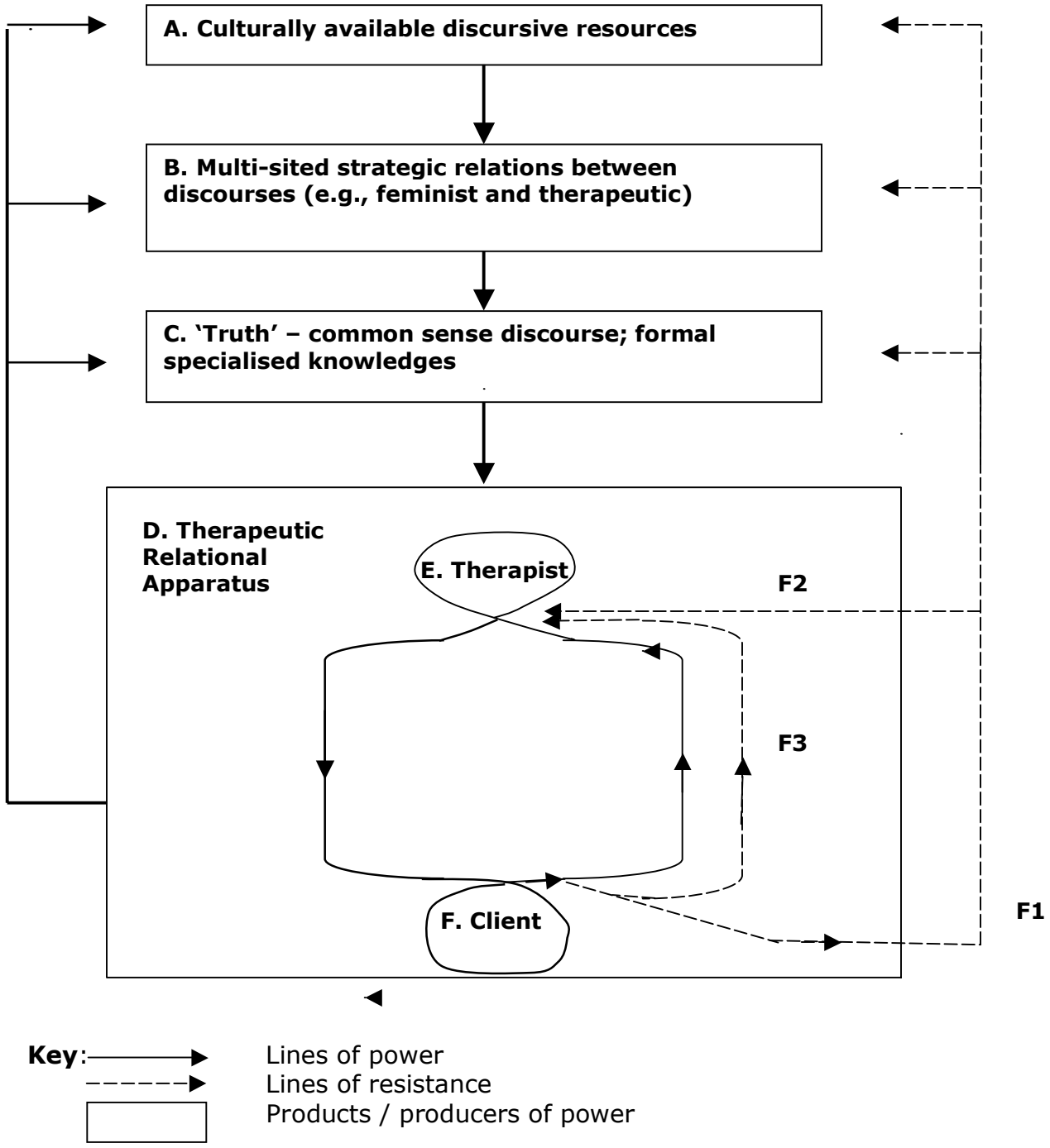

Figure 9.2.: A conceptual map of power and its products

In terms of the societal operations of power, all culturally available discourses and associated positioning possibilities (i.e., in A) can in principle be measured against and situated with respect to prevailing standards of truth (C). With respect to our specific concerns, the formation of certain truths (e.g., the acceptance of self-contained individualism) and associated arrangements of discourses (e.g., individual and psychological over other discourses on the matter of personal problems) have facilitated the institutionalisation and widespread recognizability of therapeutic practice. Indeed, therapy promises to address personal problems in the terms of accepted truths (e.g., the cultural privileging of self-containment), and seems to offer some of the most refined explanations of personal difficulties in the broader genre of self-containment discourses. Therapy is therefore well positioned to enhance and reproduce those societally extant forms of power and truth that have facilitated its own salience and recognizability: to reproduce, refine and enhance, for example, our knowledge of ourselves as self-contained individuals.

Therapy's approximate alignment with existing knowledges and reified relations of power (i.e., D with C) facilitates the infiltration into the therapeutic relationship of forces that render therapy capable of supporting and reproducing society's systems of truth. This capacity is established through the provision of: a more or less fixed relational apparatus; complementary primary positions; and differentiated speaking entitlements, degrees of influence, and types of access to specialised knowledges. Knowledges produced within therapy are then re-circulated, from the local therapeutic domain into the societal discursive network, to then become engaged with elements in that landscape at any or all levels. For instance, therapeutically inspired narratives become part of the common store of knowledge from which people can choose (i.e., D - A) (as suggested by narrative therapists Foote and Frank [1999] and Freedman and Combs [1996]). They also – particularly if they demonstrate subversive leanings - enter into discursive struggles in any number of social sites (D - B), such as familial, social, educational, occupational, professional and legal systems, or through engagements with the media. And they may become further examples or refinements of accepted, institutionalised truths (D - C). The point here is that therapy's products cannot avoid participating in and becoming integrated with societal power dynamics, in one way or another.

Having mapped out in broad strokes a way of thinking about power's circulation into and out of the therapeutic encounter, let us take a closer look at some key features of its movements. First, it is important to note the interaction between strategic discursive relations and the emergence of truth, since it is probably at this point – where there is resistance - that therapy's society-producing and reproducing functions are most easily noticed. Discursive struggles (e.g., between feminist and therapeutic understandings of personal difficulties, as discussed in chapter 5) both lead to (B – C) and are stimulated by (C – B) the macro, societal arrangements of discourses and practices that cohere with prevailing standards of truth. But the processes and outcomes of these discursive struggles are not determined purely in terms of their rhetorical or persuasive merits, in the manner of a Habermasian ideal speech situation: these discursive engagements are not distorted dialogues that thereby go on to produce mechanisms of power. Rather, their dynamics and outcomes are significantly

influenced by power relations already in place. Thus, ideas and practices may be promoted to truth status via their allegiances to and their potentials to support other already accepted practices and ways of knowing (e.g., consider therapy's alliance with the institutionalisation of the individual and associated legal, economic and medical systems). These explicit or implicit alliances give certain discourses, such as the therapeutic, a favourable position from which to undertake strategic engagements with other ways of knowing.

In the process, alternative and less favoured discourses may suffer a variety of fates. Firstly, they may be relegated or bracketed off to other domains - to address different issues. For example, feminist discourses may be marginalised in terms of their relevance on the specific issue of personal problems, but be considered relevant to issues in the socio-political domain. Therapeutic discourse is thereby freed up to continue to dominate in the domains of subjectivity and the person. Thus, certain brands of feminism might secure seemingly legitimate places in the overall diagram of power, but only on issues incidental to the question of personal difficulties. Secondly, a competing discourse may be transformed and incorporated into an expanding dominant discourse. For instance, therapy has made available limited and conditional spaces for feminist thinking within its theories, practices and training. But concerns are expressed (e.g., Heenan, 1996; Kitzinger & Perkins, 1993) that such integrations do less to advance feminist and related ideas of the political situatedness of personhood, and more to circulate ways of thinking that obfuscate the person-society link and that further entrench micro therapeutic practices as the appropriate solution to personal difficulties (as also discussed in chapter 5). Or, thirdly, alternative discourses may simply be silenced or disqualified. Consider for instance the potential fate of therapies that do not demonstrate empirically validated efficacy or effectiveness, which is an emerging standard of "truth" in clinical psychology in particular.

The second key feature of figure 9.2 to note is the therapeutic relationship itself. I will not repeat my arguments about the organisation of that relationship (see section 9.2.1, above), but wish instead to emphasise its positioning in the overall diagram of power. As depicted in figure 9.2, and emphasised in the discussion of narrative therapy in chapter 8, therapy is positioned in the manner of a relay point that facilitates the societal circulation of power. On the one hand, forces operating outside of the immediate therapeutic encounter make therapy a culturally salient and meaningful endeavour. The societal acceptance of therapeutic discourses in general effects a division of the population into experts and non-experts at the macro level, enabling in turn the construction, differentiation and institutionalization of primary subject positions of therapist (E) and client (F) at the micro intra-therapeutic level. But on the other hand, therapy's products – the talk and actions of therapists, clients and implicated others – feed back into the societal network. This can be exemplified by considering the shaping of the client. The intense discursive space of the therapeutic encounter promotes that person's subjectification. This is associated with the empowerment of the client to competently represent specifically therapeutic discourses outside of therapy itself: to make these ways of knowing available and usable (A), to implicitly or explicitly argue against alternative formulations in a variety of sites (B), and to be an example and an embodiment of

truth (C). In this way, therapy not only produces agents (therapists *and* clients) to promote its visibility and cultural relevance, but it also subtly promotes and reinforces the range of *extra*-therapeutic discourses and practices that allowed it be culturally privileged in the first instance, and which lie inherent in its formulations; such as notions of self-containment, the individualisation and psychologization of the population, and the obfuscation of socially and politically embedded aspects of personhood.

But such reproductions of truth are by no means inevitable. And so the third special feature of figure 9.2 to be noted is resistance. A client's resistance is itself a form of power to the extent that it aims to act on the actions of the therapist and to alter local power dynamics (F3). But resistance could also consist in an attempt to step outside of the intra-therapeutic flow of power; to remove some issues from that intense meaning-making space (i.e., F1 to A, B or C). This attempt, to keep certain experiences beyond the reach of therapeutic power/knowledge, is a refusal of total discursive capture: a protection of one's otherness. This does not necessarily mean the client walking out of therapy, but may involve attempts to limit what is spoken about or interpreted. This can be exemplified by the client (in extract 1, chapter 2) who refused to discuss aspects of his home situation in therapy, despite the therapist's interpretive efforts. What is interesting here about that study is that therapist-participants all deemed it legitimate to interpret his refusals, and thereby to recycle them back into the therapeutic space (i.e., F2).

A second example comes from the case of Megan in chapter 5. While she was prepared to entertain therapeutic interpretations of certain aspects of her life (e.g., regarding her perception that others lied to her), she refused to give any kind of psychological meaning to her eating behaviour. That specific issue was not made available for therapeutic capture (i.e., it traced the lines of F1). However, over time, her constructions of herself and her problems became increasingly psychologised, and her resistance became vulnerable to reinterpretation. In other words, her proposed area of otherness (i.e. the meanings she ascribed to her eating conduct) was redirected into the therapeutic domain (F2), to be re-constructed so that it became therapeutically accessible and familiar. But what we must also attend to in Megan's situation is the number of extra-therapeutic forces already pressing for her eating conduct to be known within – and not outside of – therapy. Indeed, I noted in chapter 5 that her parents, her friends, other professionals, and possibly also invisible others, "common sense" knowledge and the media, were already in collusion with that strategy. The recycling of her resistances back into the therapeutic space was facilitated not only by the therapist's rhetorical tactics (F2 - and back into the local relational system), but also via her disadvantageous positioning in the strategic struggles she was personally engaged in outside of therapy (F1 - B), and the consequent push for her to understand her behaviour in ways that the surrounding culture considered truthful (F1 – B - C): in this case, as a specifically *psychological* issue.

Anderson's not-knowing therapy (as discussed in chapter 6) can also be considered in terms of this internal and external capturing of resistance. Anderson demonstrates a sensitive responsivity to the speech of the client, and takes responsibility for being respectful of any client's demonstrations of resistance (Anderson, 1997, p. 125) (F1, F2 or F3) by not deliberately imposing any sort of

meaning on the latter's experience. This may obviate the need for continued in-session resistance (F3), and it is possible that her approach may even permit areas of client otherness to escape the sub-diagram altogether (F1), and not be discussed (i.e., are ejected from D and not returned into that space). This does not, however, prevent the client from being culturally constructed as a client, or from assuming the appropriate client position in the first place, or from being pressured by others outside of therapy (i.e., through B and C) to open herself up to therapeutic insights. These intra- and extra-therapeutic forces may apply regardless of the therapist's intentions, since these intentions form only one small part of the multiple forces exerted on the person of the client. The therapist's behaviour is itself only one small aspect of the "total structure of actions" that impact on the actions of the client, and thus should not be considered independently of the ensemble of actions in which it is embedded.

These pathways of resistance may also be relevant to understanding the work of those more overtly critical therapists – such as narrative and feminist practitioners – who do not aim to reinterpret the client's resistances so much as they seek to *join* the client in his or her resistances against forms of power encountered in the macro sphere and discussed in therapy (as argued in chapters 7 and 8). As has been argued, however, and as illustrated in figure 9.2, such resistance must inevitably negotiate in some way with a variety of forces to be found outside of the therapeutic arena itself. I turn now to consider this issue in more detail.

9.2.4.2. The possibilities of a critical therapy

Can therapy, in its reflexive relationship with sociocultural processes, function to undermine or meaningfully challenge societal networks of power, outside of the therapeutic relationship itself? I have already argued that therapeutic discourse is capable of capturing and transforming politically challenging discourses (such as feminism). But in chapters 7 and 8 I explored the possibilities of resisting such neutralisation, and of the tasks associated with sustaining a political view of personal life in therapeutic practice. Psychoanalysis and narrative therapy were discussed in this light, complementing the discussions on feminist therapy with respect to the bulimia case of chapter 5.

In both cases – in psychoanalysis and narrative therapy – it was argued that difficulties face the politically radical or resisting intentions of therapists. Both psychoanalytic and narrative therapeutic theories are at risk of neutralisation by broader, more powerful and typically individualising discourses and practices (as was argued in relation to feminist therapy in chapter 5) (i.e., in the recycling of their resisting ideas into the societal circulation of power – F1 to A,B and C). Psychoanalysis has become politically "spread," integrated with a number of political strategies that are sometimes diametrically opposed to each other, such as on the issue of homosexuality. In terms of figure 9.2, this means that psychoanalysis has become invested with a number of discourses and practices in the context of their strategic engagements (B), some of which have led to its integration with culturally prevalent truths (C). Narrative therapy may be in the early stages of facing the same kind of political dispersion. Its concerns about power, resistance, the internalisation of problems, and the disciplinary effects of

expert knowledge are being subverted as its techniques (e.g., identifying and transforming stories; the externalisation of problems) are increasingly being used to purely pragmatic, narrowly "therapeutic" effect. Narrative therapy is thus at risk of being reduced to a relatively new store of therapeutic "tricks" for the resolution of problems in decidedly individual, rather than political, social or cultural ways. These transformations – of psychoanalysis, narrative therapy and indeed feminist ideas - may be considered products of the strategic engagements of these critical discourses with those more recognised ways of knowing and practising that have attained truth status, and which are favourably integrated with existing institutions and power arrangements (i.e., F1 – B – C, in figure 9.2). Via these engagements, therapeutic critique is easily recuperated and tailored so as to operate in the service of truth; so that they conform to accepted notions of the person, of problems, and of the role of therapy (B – C – D).

I therefore argue that operations of power at the macro level not only shape what therapists and clients do and how they do it, but they also significantly influence what sorts of therapeutic practices are likely to be available. In the process they circumscribe what therapy can achieve or produce as a socio-cultural and political force. It is hypothesised, as noted in chapters 7 and 8, that the political orientations or leanings of the different therapies tend to be given shape by broader political strategies that are available in the culture (A), and which "compete" for discursive ownership of the person (B). One might therefore expect that discourses linked in with existing power structures in the broader societal system are likely to be reproduced – supported, nurtured, and made to appear reasonable or even necessary – by therapeutic practices in general. On the one hand, therapeutic theories and practices that implicitly or explicitly align with, for example, dominant medical, educational and legal systems may well enjoy a "comfortable fit" with a variety of dominant cultural strategies, such as: the individualisation and decontextualization of problems to divert attention from macro processes that impact on the personal domain; the categorisation of problems to enable swift, efficient and cost-effective medical, psychiatric, psychological, educational and legal practice; and the promotion of conformism with existing structures and institutions in general. But on the other hand, therapies that align with more subversive or challenging political strategies (e.g., feminist- and narrative therapy with feminist politics; anti-individualising systemic therapies with the ecology movement; some forms of psychoanalysis with the gay and lesbian activist movements in the 1970's, or with socialism; and so on) clearly fit less comfortably in that broader system, and thereby become vulnerable to incorporation, redirection or outright dismissal.

The result is that these critical approaches become less available to clients *in their critical form*, and end up having only minimal impact on the sociocultural realities in which they are interested. Part of the reason for this – as alluded to in chapter 7 - may be that the challenging political objectives (e.g., those of feminism, socialism or environmentalism) in which these therapies are overtly or covertly "homed" are themselves often marginalised, disqualified, strategically displaced, placed under threat, or at risk of dissolution. They tend not to sit easily with common-sense discourses about the person, and thus have not attained the necessary truth status to facilitate the systematic and widespread production of social realities in their terms. Such deviation from common-sense may to some

extent account for the tendency of critical therapists to avoid overt discussion of political issues, or of their politicised views of therapy, the person, and the problem, with their clients (e.g., Freedman & Combs, 1996; Monk & Gehart, 2003). The idea that the "personal is political" is simply not a widely accepted notion. But by concealing these issues, these therapies risk remaining trapped in an impotent feeding of the culture with new and creative discursive resources (D – A), but without becoming meaningfully engaged in the discursive struggles (B) required for the subversion and possible alteration of regimes of truth (A). Indeed, the danger of such engagements is transformation and political neutralisation. The result is that critical therapies are at risk of becoming available to clients only when they have been politically tamed and integrated with more widely available, accepted or taken-for-granted strategies.

We cannot consider what therapy helps produce at the societal level – therapy's broad-scale contribution to the shape of the social world - without considering the vast network of power relations that shape its practices. As suggested in chapters 7 and 8, this does not mean that therapeutic practice is doomed to conservatism and the reproduction of societal power relations. But it might mean that much more than a critical theory or radical impulse is needed. To this end, a strategy of multiply constructed, transversal resistance was suggested.

9.2.4.3. Cautions

A few clarifications must be made in relation to the circulatory model proposed in figure 9.2., which should be considered a tentative and exploratory theoretic-analytic model based on the discussions presented in this thesis.

First, is escape from the diagram possible? I suggest it is possible to escape from this *particular* diagram to the extent that discourse struggles lead to the production of new forms of truth (B - C), but that escape from diagrams of power in general is not possible. Power is immanent in the social sphere, and any system of social order and organisation is bound to construct power relations and technologies for the shaping of human conduct. In conditions of social and cultural change the topography of the diagram would alter; new lines of power could then be traced, new applications forged and new institutions created. The key to change, perhaps, lies in resistances to power enacted in discursive struggles (depicted in B), the outcomes of which might alter the flow and the *products* of power from that point onwards. Were that to be the case, then I suggest that in a new diagram, escape would again only be possible to the extent that new forms of resistances (specific to the diagram of power in which it occurs) are raised and focussed to effect yet another form of change. This is what rescues this account from being overly pessimistic and encapsulating.

Second, this is not intended to depict a historical or developmental process, in which the processes to which A, B, C and D refer are seen as sequenced developmental stages of power. Rather, I separate these analytically, merely for purposes of clarity. Thus, one cannot strictly speaking separate out institutional requirements of individuality (C) from therapy's positioning of individuals (D): the therapeutic relationship can itself function as institution of individualisation. Their analytic separation, however, helps create a view of contextual conditions that make the relationship possible and meaningful. It also helps us to see that

therapy (D) is not the only possible product of truth (C), but that it does depend on existing truth trends for its stable existence as a form of practice. Similarly, the strategic relations between discourses (B) may play out in varying ways *within* institutions (C), including therapy (D), and so it would be somewhat artificial to say that discursive struggles (B) precede established truths (C) which in turn precede therapeutic practices (D). The separation between discursive struggles and the distillation of truths serves merely to distinguish processes that are likely to be empirically indistinguishable much of the time. I suggest that processes of struggle (B) lay out the discursive possibilities and constraints out of which the reification and institutionalisation of certain discourses becomes possible (C). For instance, feminism's critical engagement with therapeutic discourse has led to the requirement that therapeutic institutions formulate some ongoing response to this discursive competitor (e.g., through the creation of feminist therapy). Also, the emergence of dominant discourses (C) might in turn promote further processes of discursive conflict or renegotiation (B) as resistances are incited against them.

Thirdly, this diagram does not do justice to the subtle intricacies of communication that occur within therapy, or to the numerous ways in which clients and therapists influence each other. Instead, it highlights possible pathways for power, but does not show the client's access to forms of power that could undermine at least some of the forces being exerted on him or her, such as access to legal protection in the event of therapist abuse, the option to leave therapy altogether, or to ignore the therapist's comments. The impact of these processes on therapy and on the client have not been explicitly examined in this work, but I suggest that society's power network is designed in such a way that these actions can easily themselves become subject to therapeutic re-interpretation inside of therapy or to reinvestment in the higher levels depicted outside of therapy. Nevertheless, the fact that clients have such protections and options indicate that the therapeutic relationship is not one of domination: an escape from that immediate field is possible, and this is one way in which it becomes possible for the client – if she or he so desired - to avoid the objectifying and subjectifying gaze associated with the incitement to discourse and the therapist's discourse. But as figure 9.2 suggests, it does not render the client invulnerable to the related individualising effects of social and cultural institutions and perceived truths (C). It is important to note that this is not a model of therapy, but a rudimentary proposal for thinking about the circulation of power and its impact on and within therapy.

Fourthly, there are numerous other relevant social and professional processes that could be depicted, but that I have for the sake of clarity chosen not to include. For example, as alluded to in the last point, the client's access to legal and formal ethical protections are not depicted. There is also the obvious point that the reification of the individual at the institutional level (C) occurs in numerous sites and relationships, and is not exhausted by the therapeutic relationship (D). Further, there are complex relations between the therapeutic domain (D) and the knowledge and practice domains of psychiatry, medicine, law, education, religion, and so on, that participate in different ways in strategic discursive processes (B) and institutional processes (C), and which might sometimes interface directly in one way or another with the actual therapeutic

relationship (D), and on the conduct of the therapist or client (e.g., when the therapist testifies for the client in court).

Clearly, this is by no means a comprehensive diagram of power, but I offer it here as a possible point of departure for the further examination of therapy's relationship with the societal context.

9.3. Limitations and areas for future study

Five critiques of this thesis are presented, some of which can make visible new avenues for study: (1) the appropriateness of the use of case studies to make general claims about therapy's position in a broader cultural network of power; (2) the apparent contradiction between the valuing of disqualified knowledges, and my self-presentation as "expert," knowing interpreter of power; (3) the reification of the concept of discourse; (4) the possibility of different interpretations of data and the predispositions of the methods used in these studies; and (5) the limited account of resistance developed in this work. Each of these will be addressed in turn.

9.3.1. The use of case studies

Four studies in this work focussed on analyses of specific cases, of which three were taken from my own therapeutic work. A variety of issues arise as a consequence: (1) the problem of generalizability; (2) the use of my own case studies; and (3) the limitations of case study formats in the examination of power. I will discuss each in turn.

First, the issue of case studies and the problem of their generalizability: Case studies are particularly useful as means for providing detailed examinations of processes under study. In this instance, case material is vital to a consideration of how power might be exercised, enhanced, refused or undermined in an actual therapeutic situation. Using a discourse analytic method, it becomes important to bracket therapists' *claims* to practice in this or that way, or to use theoretical knowledge in one way or another, and to focus instead on actual discourse-in-use, and to consider their discursive products, whose means of production may not always be immediately apparent. One important reason for doing so, in the context of the present work, is that power is frequently concealed *specifically* by knowledge claims: by claims about how one works; about what stance or philosophy is adopted; and about the degree of hierarchy/ democratisation emphasised in practice. These issues need investigation at the level of actual practice – we cannot say what we do without looking closely at how we do it: case studies are ideal from that perspective.

But while case examinations may be crucial, the question then arises of the degree to which conclusions drawn from them can be generalised. Thus, in the studies presented, I do not claim that all therapists use this or that specific tactic to undermine resistance (e.g., change the topic), to persuade their clients (e.g., work towards the construction of consensual doubt), or to conceal power relations (e.g., by psychologising resistance). Rather, I have attempted to elucidate the kinds of tactics that therapists *can* use, that we are *allowed to* use. As discussed especially in chapter 2, therapists derive an entitlement to construct meaning

around a client's actions – it is at the heart of what we do. On the basis of these constructions, therapists necessarily develop tactics to test these meanings, to orient future sessions or future talk around them, or to bring them into being in one way or another. Thus, the specific tactics detailed in the remaining chapters (and therapist-participants' tactics as noted in section 2.4.1. of chapter 2) are considered ordinary examples of therapeutic meaning production, and of the way in which therapists are socially and professionally sanctioned and entitled to operate. I have also assumed that the case studies presented depict therapists (including myself) behaving in ways that conform to the minimal standard of prescribed formalised ethical guidelines for engaging with clients, and in ways that are not extraordinary (with the possible exception of chapter 6 – which will be addressed below).

Thus, I have not aimed to provide a comprehensive list of all techniques for the exercise of power. Rather I have tried to follow what Willig (2001) considers the main aim of "Foucaultian Discourse Analysis": to "map the discursive worlds people inhabit and to trace *possible ways-of-being* afforded by them" (p. 120; emphasis added). The therapeutic tactics described in case studies are considered possible ways-of-practising in a therapeutic relationship. Cases were useful in identifying some of these, before moving on to the more important question: what has made this range of therapist actions *possible*? In other words, what social, cultural or institutional discursive conditions must be present for the therapist to become entitled to behave in some of the ways depicted in this work's case studies? The case material presented helped raise this question, even though they could not themselves provide an answer. Nevertheless, all of the case studies reported indicated that something else – from outside of the observable encounter itself – was influencing the talk. It thus became necessary, as discussed above, to step outside of the text to consider socially and culturally constructed therapist entitlements, and broader discursive strategic power relations before returning once again to the text to examine how these processes may have impacted on the talk presented.

Secondly, there is the issue of the use of my own case material in chapters 3, 4 and 5. One potential critique is this: How can I be sure that my own practice in any way reflects the work of other therapists? Initially, my reason for analysing my own work was to become critically aware of what *I* – and not anybody else - was doing in therapy, as part of a reflective practice. But then, as noted above, my interest evolved into a concern for how these practices became possible or permissible in the first place: Why were clients listening to me, even when I was unsure about where we were headed? Why did I need to speak in a therapeutic language rather than any other? And if I used another language, was I still being a therapist, or was I stepping beyond the bounds of my competence? It seemed evident to me that these questions could reasonably be applied to any therapeutic practice, and that they were not raised by the unique properties of my own work: they seem endemic to therapeutic work in general. Out of these concerns, I was able to develop this series of studies, which I defend here precisely as examples of "ordinary" therapeutic thinking and practice: as permitted, "possible ways of being" in therapy. Nevertheless, I gained much from analysing the work of Harlene Anderson (chapter 6) as a kind of test, or counterpoint to my own work, which facilitated consideration of the more subtle question of how the therapeutic

power/knowledge network might operate with the therapist's deliberate *non-use* of expert knowledge. Therefore, I cannot be certain what would have emerged had the work of additional therapists been analysed. This is clearly an important area for future research attention.

There is an important argument to be made for attending to different therapeutic approaches with a case study format. Our knowledge in the area will obviously grow as we consider different techniques and knowledge forms deployed in therapy, and refrain from making general judgements from a confined sample of case studies. Indeed, narrative therapy figurehead Michael White argues that the blanketing of therapies on the basis of the therapist-client power imbalance might mask and undermine the variety of struggles against domination that can be promoted in therapy (in Hoyt & Combs, 1996, p. 39; see also Larner, 1999). Therefore, empirical analyses of the case work of avowedly critical practitioners might promote further insight into how the politicisation of talk and self are achieved in therapy, and help raise more refined questions about the ethics of such transformation (or, perhaps, joining). As an extension of the case studies presented here then, it would be useful to further analyse what critical therapists do with their clients. In particular, we might examine the techniques associated specifically with the therapist's critical interpretations; that is, the points at which therapists believe themselves to be "joining" their clients in resisting aspects of societal power mechanisms (see chapter 8).

This leads on to the third point: although they provide useful points of entry, we obviously need more than just case study formats to adequately research power. Thus, with regard to the matter of therapists' alleged joining with clients' resistances, we might interview clients regarding their experiences of being "joined": Do they experience this as a joining, or as the therapist's invitation to a new way of thinking (as suggested in chapter 8)? Also, we need to examine to what extent and in what ways therapeutically generated critical ideas and practices are gathered up from within therapy to be deployed in the broader context: in the training of therapists; in procedures of referral; in its impact (or lack thereof) on lay talk about the person and about problems; or, more broadly, in the strategic relationships between therapeutic and alternative ways of knowing and doing. We might extend research into this micro-macro relation in any number of ways; for instance, by interviewing critical practitioners with respect to how they make their work known to referrers and other professionals (e.g., as critical or not), and with regard to the impact of such disclosure/ non-disclosure on their work and its numerous products (e.g., on reports to referrers, team meeting discussions, therapy notes, court testimonials, etc.) (i.e., the processes depicted by D – A/B/C in figure 9.2). And then with respect to the client, we must consider the degree to which clients deploy their therapeutically inspired critical understandings and associated practices outside of the consulting room. How do they engage with communities outside of therapy, and how are their therapeutically inspired critical ways of knowing maintained or subverted at that level (i.e., D - B in figure 9.2)? What sorts of truths emerge in that person's family, groups of friends, community, and so on, and to what extent are these others influenced by – and indeed, to what extent do these others influence - the new critical interpretations? Are these critical interpretations lost or transformed

through such engagement (i.e., F1), or is their lifespan confined to the level of private thought, or to that of the therapeutic domain?

My point here is that case studies have their limits in terms of their capacity to be informative about power (i.e., they are not designed to tell us in much detail anything operating outside of D in figure 9.2). We do not need a detailed examination of each and every form of therapeutic practice in action. I suggest that there is a more urgent need for a focus on the ways in which these local in-session practices and their products are, to reiterate the words of Foucault (1980), "invested and annexed by more global phenomena and the subtle fashion in which more general powers or economic interests are able to engage with these technologies that are at once both relatively autonomous of power and act as its infinitesimal elements" (p. 99). Such examination necessarily take us outside of the realm of "pure" psychology, beyond the immediate texts of case studies, and more towards a confluence of the sociological, political and psychological domains. But if we wish to understand the functioning of power in therapeutic work, this is a direction in which we will need to go.

9.3.2. My position as expert knower or interpreter

The specific suggestions for future research offered above rest on the claims and arguments I have made in this work. But am I not also, in presenting these studies in this way, reaffirming the authority of expertise, claiming that I "know best", and that I have seen things that others do not see? There is a deep epistemological problem that plagues both constructionist and discursive viewpoints, and which I therefore also inherit.

The problem can be simply posed: Against what are the claims of this work to be judged? For example, if the diagram I propose above (figure 9.2) is to be of any value, surely it cannot be considered – indeed, I cannot consider it – "merely" a construction, as good or as viable as any other constructed view. And yet Gergen (2001) might consider this claim an attempt to "arrogate (myself)… to the status of (a) minor god" (p. 425). But then, on the other hand, Burman (1996) denounces the "relativistic reading of discourses as *merely* social constructions floating free of material practices" (p. 8). I concur with a host of authors in the discursive tradition who posit that there is a material reality that we can talk about, and that our discourses and practices are grounded within it; but also that we can use discourses to create meaning out of the real objects and forces we encounter, and that these constructions influence our behaviour and our interactions to the point of constituting a social reality that has nevertheless to engage with ontologically extant objects and forces (c.f., Burman, 1996; Kendall & Wickham, 1999; Nightingale & Cromby, 2002). This is preferable to an eternal discursive relativism, in which the tenability of any of the proliferating and divergent beliefs and views in society are granted equal footing, and all claims become "just interpretations".

However, it is one thing to believe in the existence of an ontological reality, but quite another to claim to know it. In this regard, I cannot claim to have *discovered truths* about therapeutic interactions and their relationships with power. I have indeed engaged in much interpretation to construct the views presented here. I enter and interpret the therapeutic world with my own

"agenda"; with my own sense of societal injustices and with a commitment to aim my work towards addressing some of these. Specifically, I believe therapy needs to be more overtly socially and politically situated, so that we can better – and more critically - understand what sort of world we are helping to create. This belief is not so much underpinned by an interest in discovering the truth about personal problems or therapeutic relating, but by a motivation to construct ways of thinking that highlight – or reinterpret - these processes as social and political phenomena. Thus, my point is not that the notion of individuality is a fallacy (although it is a persuasive argument – see, for example, Sampson [1993], as discussed in chapter 4), but that individualism is a dangerous practice to the extent that it conceals our sociality and our participation in networks of power. Further, it is not that I consider psychological correlates of eating disorders to be unimportant, but that their salience easily persuades us to ignore the obvious social inequalities with which they are associated, but which they could help to highlight (see chapter 5). In other words, to some extent I entered this project with a prior, though broad, sense of how therapy should be understood; with the ambition of encouraging the field's cultural and political accountability. My arguments are "just interpretations" in the sense that any number of alternative meanings could be generated (see section 9.5.4. below). However, my hope is less that the minutiae of my arguments will be considered "truthful", and more that they succeed in highlighting the question of therapy's political participation. Thus, the arguments presented are offered as proposals or hypotheses.

It should also be noted that there is a paradox inherent in my use of knowledge to critique uses of knowledge. I can only acknowledge that my own proposals are of course also subject to operations of power, to the extent that they are circulated. After all, they are designed to lend shape to therapeutic thought and practice, and must therefore at some level participate in – and cannot stand above - networks of power. They are potentially as tactically polyvalent - and hence vulnerable to deployment in unintended ways – as any of those ways of knowing discussed in this work. They may also function to shape up an understanding of power that not only impedes our vision of certain important and beneficial features of therapeutic relating, but perhaps other aspects of power as well. As noted earlier, Duveen (1988) suggests that "(a) representation… is not only a way of understanding something, it is also always a way of not understanding something" (p. 461). My own attempts to make salient the issue of power will inevitably involve a clouding of other issues.

9.3.3. The reification of discourse

In these studies I have reified "discourses" (e.g., therapeutic discourses, medication discourses, etc.) by putting them in noun form, as if they were entities to be uncovered in analysis. As Parker (1994) notes, discourses "are not really there hidden away awaiting discovery; they are indeed produced through analysis" (p. 104). I have used the term in a way that structures, and therefore supersedes and even colonises the actual speech of therapists and clients. As Parker (1994) goes on to argue, however, such a depiction lends "coherence to the organisation of language" (p. 104), and permits a mapping of relationships between local practices and macro processes. It becomes possible to trace *a*

discourse from one domain to another (e.g., micro to macro levels) in a way that the use of actually spoken terms or words would probably not facilitate. There is the risk, nevertheless, that in doing so I might miss certain key features of interpersonal relating, and render invisible opportunities for different forms of action through my employment of an overarching and encapsulating "therapeutic discourse" category. Despite this limitation, it has been useful to reify the idea of discourse in order to highlight – hopefully without having oversimplified - a series of issues that it has become easy for therapists to overlook in their theorising, practices, teaching and research.

9.3.4. The possibility of reinterpretation and the predispositions of methodology

This raises the problem of interpretation. I have used a specifically Foucaultian theoretical orientation, which predisposes my analysis in particular directions. Specifically, social action is interpreted through the lens of power which – like the concept of discourse as mentioned above – might in turn conceal certain aspects of therapeutic relating. It is important to note therefore that very different interpretations of the data could be constructed. My observations may have been limited by theory in at least one important respect. Resistance, both as a concept, and as a practical possibility for shifting the power relationship, was not adequately developed in this work, despite my intentions to do so. Thus, while in chapter 1 I took issue with Billig's (1996) concern that Foucault's work biases towards a closing down of dialogue through his emphasis on domination, in the end I have not managed to construct a view of *client* resistance in a way that allows it to effectively challenge the therapeutic power relationship, except perhaps to appeal to clinicians to "respect" their client's words. I have assumed that this may tell us something about therapy, and the imposing power effects it has on clients; but it may well be argued that this is a consequence of the type of analysis I have used.

However, while the latter possibility is acknowledged, the noted impact of resistance on power relations in a non-institutionalised setting (e.g., scenario 2 in chapter 2; and extract 1 in chapter 5), in contrast to the muted interpersonal effects of client resistance in therapy (as evident in chapters 2, 4, 5 and 7), suggests that the development of the concept of resistance might best be developed by considering its effects in more fluid and less institutionalised power arrangements. I suggest, in other words, that this indeed tells us something about *therapy*; but I acknowledge simultaneously that there is much more about therapy that may well be obscured from view, or at least de-emphasised, through the use of power-resistance as the primary analytic.

9.3.5. A pessimistic view of client resistance

I have defended the restricted version of client resistance developed in this work, as being not so much a feature of my methodology as a feature of resistance's relative impotence in shifting the power relation in therapy. But, this is not to play down the limitations of a Foucaultian view of resistance, as his work stands. There is enough in Foucault's "tool-kit" of concepts to warrant its retention. His work

disconcerts, agitates and unsettles; it opens up questions that might otherwise not be considered, and indeed, it is my hope that this thesis functions along these lines. But the limitations regarding the issue of resistance need to be addressed if we are to avoid the paralysing effects of seeing power as domination. I suggest that the ideas of certain authors may be more useful in this regard than I have given them space to demonstrate.

First, Falzon's (1998) interpretation of Foucault's work as susceptible to *development into* an account of human interaction as dialogue-with-power holds much promise (briefly articulated in chapter 7). This reformulation might facilitate enough of a shedding of the legacy of domination, from which Foucault's "power" is not always clearly distinguished, to permit a more nuanced and optimistic view of resistance. Secondly, and as already argued in chapter 4, Billig's (1990; 1996) notion of talk as argumentation and as consisting in processes of criticism and justification, in its coherence with a dialogical framework, offers tools for the analysis of the dynamic relationship between resistance and power in the minutiae of actual talk. We could potentially note, in other words, precisely how client discourses influence the therapist's talk rather than merely the other way around. And thirdly, as discussed in chapter 7, the view implicit in Habermas' formulation of communicative action (and in the accounts of many others, it should be noted), that people should at least *try* to be fair, and to attempt to hear the other as other, pushes us to incorporate the often ignored factor of *intentionality* into analyses of power dynamics. Falzon's position, together with what I have retained from Habermas, broadens out research horizons and complexifies the field, because they enable not only understanding and supporting resistances from within (the focus of Foucault), but the development of respectful dialogical tools for consideration by those who occupy positions of power. Certainly there are difficulties to be negotiated in undertaking such a project. For example, there is the problem of normativity, and the related challenge of avoiding a position external to power in trying to speak both to those who resist and those who are resisted. Nevertheless, Falzon, Habermas and Billig point to important areas for theoretical and empirical consideration, which orient around the idea of resistance within dialogue.

9.4. Conclusions

Finally, I do not deny that therapy practices can be used to positive effect in the reduction of human distress and misery. I also acknowledge, given the extent of critique offered in this work, that therapists aim to be of benefit to their clients, and that to the extent that power is recognised, it is oriented towards being a "power *for*" the client (Larner, 1999, p. 48; emphasis added). And certainly, many – perhaps most - clients would recognise this, and feel supported throughout their therapeutic experience. Rose (2001), who has used many of Foucault's ideas in performing critical analyses of psychology and its techniques and language, urges critics to be respectful of therapy and its practitioners, given the level of good will, positive intent and client benefits involved in such practice. It should therefore be re-emphasised that the criticisms offered here have little to do with therapist intent, or with whether or not personal gains are made by clients. It is aimed at another level entirely – at a different set of questions - that allows us to see how

both therapist and client become positioned by a much larger discursive and practice network; which in turn requires that they adopt positions relative to each other such that the client becomes not only a knowable, calculable and measurable object, but also an uncertain and malleable being; and such that the therapist becomes an applicator of a knowledge that belies its strategically constructed nature by posing as truth. Our intentions should not prevent us from being critically aware, not merely of the *way* in which we practice therapy, but of the fact that we practice therapy at all. Critique requires that we momentarily step back from therapy as a whole, to consider the possibility that we operate as participants within, and as co-authors of, a societal network of power, and to ask what other discursive and practice options there *could* be, to wonder why and how some of these options have become marginalized, and to perhaps ask what has prevented some of them from even being thought.

I would like to end with a quote from Falzon, who earlier I suggested might offer a Foucault-inspired way forward in the analysis of the relationship between power and resistance. He claims that dialogue

> gives weight to the other… as that which absolutely exceeds the categories the self imposed on it, and is able to affect the self in turn. There is no position which stands above the movement of dialogue, and one side can only ever achieve a temporary victory over the other. In the end, both sides are subject to endless transformation. This is a non-totalising, open-ended dialogue or interplay, with no pre-ordained path, no predetermined moves, where moves never come to an end (1998, pp. 42-43).

This version of dialogue may be impossible in therapy, without a capitulation of therapist-client subject positions. But then, this is not only up to the therapist; and even if it were, could it still be called therapy? To the extent that dialogue is a priority, we may have to be content with engaging in what Larner (1999) refers to as a "dialogue of unequals" (p. 48). This inequality matters a great deal, because it has far reaching consequences. It is only the starting point of therapy's complex and problematic relationship with power.

9.5. References

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SUMMARY

Despite sporadic attention to the issue, the therapeutic professions lack theoretical frameworks and empirical tools to examine the way in which power operates in the therapeutic encounter. This thesis attempts to address this situation, firstly by orienting to the ways in which power is hidden in therapeutic practice, which accounts to some extent for the limited and fragmentary attention given to the issue, and secondly by proposing theoretical and methodological tools to make power visible. In doing so, I develop a view of power based principally on the ideas of Michel Foucault. This approach to power is useful because it not only facilitates an understanding of local therapist-client dynamics, but also promotes investigation of therapy's function in the overall sociocultural and political context.

Four questions provide the cornerstones for this thesis: (1) What forces impact on participants in the therapeutic encounter? (2) How is power concealed in therapy? (3) How can it be made visible? (4) What is the relationship between therapeutic power and the operation of power at a societal-political level? Each of these questions is addressed in different ways in the studies presented, and answers to each of them are proposed in the final chapter.

Chapters 2 to 6 focus on the clinical relationship itself, and note that its shape is significantly influenced by forces that lie external to it. In chapters 2 and 3 the a priori structuring of the therapeutic relationship is discussed. The notion of 'primary positions' is put forward to highlight the idea that therapist and client typically orient to each other not as unknown others, but precisely *as* therapist and client. In chapter 2 it is argued that this mutually complementary orientation allows the therapist to perform interpretive activities that in other settings would be seen as ethically problematic, demanding or intrusive. And yet therapeutic knowledge can reconstruct such actions as ethical and unproblematic. The client is thereby positioned in vulnerable fashion within therapy's power/knowledge network. Chapter 3 argues that these primary positions are culturally produced and create a therapeutic relational system, which organises the circulation of power in the encounter so that the therapist's words are invested with a shaping force, and the client's words with a weaker suggestive or implicative force. This arrangement is by no means universally evident, but the therapeutic interaction may encounter persistent pulls – from inside and outside of therapy – towards the culturally constructed structure of that relationship.

The prior inequality structured into the relationship, as discussed in chapters 2 and 3, is further supplemented with therapist technique and the use of interpretation. Chapter 4 focuses on therapy talk as rhetorical or argumentative in nature. A family therapy case demonstrates the therapist's use of persuasion to move the family not only towards the therapist's preferred constructions of the client's behaviour, but towards acceptance of the therapist's unwitting support for a Western, self-contained, account of how problems should be understood and resolved. The question is posed of whether therapy leans towards the promotion of this version of personhood, although attempts by some therapists to avoid such individualism are noted.

But the therapist's discourses can only be productive of effects if the client internalises them to some extent. Chapter 5 examines a case of bulimia, in which the client's initial refusal to interpret her eating conduct in a psychologically

'appropriate' way is eventually overcome by subtle therapeutic re-interpretation. Significantly, the client eventually internalises aspects of the therapist's discourse to the point where she can recognise herself, despite her initial resistances, as a bulimic in a specifically psychological sense. Primary positions and rhetoric combine to produce a shift in her subjectivity. In the process alternative discourses, such as those of the client and of feminism, are undermined as candidates for the task of understanding her behaviour. It is noteworthy that the critique the client could provide of therapy and the therapist – via her resistance – is hidden to the extent that her refusals are reconstructed in a more psychological than interpersonal or political discourse. Therapy is seen as one of the many local sites in which strategic engagements between competing discourses can take place; the client and therapist are thereby positioned inadvertently as political participants.

As a counterpoint to preceding discussions of therapy as a power/knowledge network, chapter 6 considers Anderson and Goolishian's claims to have overcome power via "not-knowing"; by detaching power from knowledge. Analysis of a session by Anderson reveals her reliance on special speaking arrangements in that local instance to promote an illusion of therapeutic egalitarianism. Indeed, Anderson's disciplined attempt to avoid power becomes the most convincing argument for power's pervasive presence in the encounter. Power is not overcome but may be concealed by these practitioners' theoretical claims.

In chapters 7 and 8 the focus moves away from the local encounter itself, to examine the possibility of a critical therapy: a practice that challenges rather than conforms to existing societal power arrangements. Previous discussions of therapy's tendency to conceal social and political factors through its support of individualising discourses, and its undermining of alternatives (as noted especially in chapters 4 and 6), become relevant here, as I consider approaches that seek to 'politicise the personal'.

Chapter 7 discusses Habermas' contention that psychoanalysis is a critical and 'emancipatory' practice that liberates people from the distorting effects of power. However, Habermas situates critique in external relation to systems of power, and this creates the problems of idealism and authoritarianism. An alternative view of critique is proposed, as fundamentally internal to power dynamics. It is on this basis that psychoanalysis as critique should be considered. Its tendency – though not universal – to relocate interpersonal conflict into intrapsychic space undermines its capacity to properly attend to resistances, and to hear the critiques inherent within them. That is, like Habermas' version of critique, psychoanalysis risks positioning itself in external rather than internal relation to the power relations with which it is involved: it tries to stand above power. This undermines its capacity to function as critique. However, psychoanalytic theory displays elasticity, and it has been used to support a variety of contrasting strategic objectives. This suggests that, in principle, psychoanalysis can be used to challenge existing power relations. But I argue that if it is to be critical, it needs to adopt a more strategic than neutral, truth-seeking orientation.

The fundamental problem with critical approaches, noted in chapter 7, is discussed in more depth in chapter 8. Critical therapies (and here I focus on the example of narrative therapy) are vulnerable to incorporation into political

strategies found in society. They are as susceptible to societal power dynamics as are their clients. As was made evident in the discussion in chapter 7 of psychoanalysis' more conformist elements, critically oriented techniques and concepts are easily appropriated and redirected to support the very societal practices they were designed to challenge. In response to this risk of appropriation, I suggest the tactic of 'transversal resistance', which involves the provisional joining up of diverse resistances from a range of therapies against agreed upon sources of power. And with respect to the local therapist-client relationship, a strategy of transparency regarding political interests is recommended as an ethical requirement for critical therapies.

Chapter 9 integrates the preceding discussions by addressing the four questions laid out at the beginning of the thesis. An attempt is made to highlight the fundamentally social and political nature of therapeutic practice, firstly by hypothesising a four stage sequence through which persons are shaped into the position of clienthood (drawing mainly from chapters 2, 3, 4, 5, and 6), and secondly by proposing an account of therapy's place in power's circulation through society (drawing from all chapters, but most notably chapters 7 and 8). Limitations of the studies are then noted, as well as areas for future research and theoretical development.

SAMENVATTING

Hoewel er sporadisch interesse is voor dit onderwerp, ontbreekt het binnen de therapeutische beroepen aan theoretische kaders en empirische gereedschappen om na te gaan op welke wijze macht functioneert in de therapeutische ontmoeting. Dit proefschrift probeert dit vraagstuk te verhelderen, allereerst door de manier waarop macht verborgen wordt in de therapeutische praktijk onder de loep te nemen – een gegeven dat ten dele verantwoordelijk kan worden gesteld voor de beperkte en gefragmenteerde aandacht voor dit thema - en daarnaast door het aanreiken van een aantal theoretische en methodologische handvatten om macht zichtbaar te maken. Op die manier wordt er een visie op macht ontwikkeld, die voornamelijk gebaseerd is op de ideeën van Michel Foucault. Deze benadering van macht is niet alleen nuttig omdat ze de onderlinge dynamiek tussen therapeut en cliënt beter laat begrijpen, maar ook omdat ze de functie van therapie in de algemene socio-culturele en politieke context dieper exploreert..

Vier vragen vormen de hoekstenen voor deze thesis: (1) Welke krachten beïnvloeden de deelnemers aan een therapeutische ontmoeting? (2) Hoe wordt macht verborgen in therapie? (3) Hoe kan die zichtbaar gemaakt worden? (4) Wat is het verband tussen therapeutische macht en het functioneren van macht op sociaal-politiek niveau? In de hier beschreven studies wordt elk van deze vragen op verschillende manieren benaderd en in het laatste hoofdstuk worden antwoorden op iedere vraag gepresenteerd.

Hoofdstukken 2 tot en met 6 focussen op de klinische relatie zelf en stellen vast dat de vorm ervan in belangrijke mate wordt beïnvloed door krachten van buiten die relatie. In hoofdstukken 2 en 3 wordt de *a priori* structuur van de therapeutische relatie besproken. Het concept 'primaire posities' wordt naar voren geschoven om de idee te benadrukken dat de therapeut en de cliënt van nature niet als onbekende buitenstaanders op elkaar georiënteerd zijn, maar juist *als* therapeut en cliënt. In hoofdstuk 2 wordt beargumenteerd dat deze wederzijdse complementaire oriëntatie de therapeut toelaat interpreterende acties te ondernemen die in andere omstandigheden als ethisch problematisch, zeer veeleisend of te indringend gezien zouden worden. Toch kan therapeutische kennis deze acties als ethisch verantwoord en niet problematisch reconstrueren. De cliënt wordt hierbij op een kwetsbare wijze gepositioneerd binnen het therapeutisch machts-/kennisnetwerk . Hoofdstuk 3 geeft aan dat deze 'primaire posities' culturele producten zijn en dat zij een therapeutisch systeem creëren dat de circulatie van macht in de ontmoeting op zo'n manier regelt dat de woorden van de therapeut een vormgevende kracht meekrijgen en de woorden van de cliënt slechts een zwakkere suggestieve of impliciete kracht. Deze afspraak is zeker niet universeel duidelijk, maar de kans bestaat dat de therapeutische interactie voortdurende krachten ondervindt – zowel van binnen als van buiten de therapie – die haar in de richting van de cultureel opgebouwde structuur van een dergelijke relatie duwen.

De ongelijkheid die inherent is aan de therapeutische relatie, zoals besproken in hoofdstukken 2 en 3, wordt verder onderbouwd door het aanwenden van therapeutische technieken en het gebruik van interpretatie. Hoofdstuk 4 focust op het therapiegesprek als zijnde van nature retorisch of suggestief. Een case study van een familietherapie laat zien hoe de therapeut overtuigingskracht

niet enkel gebruikt om de familie in de richting te duwen van zijn geprefereerde interpretaties van het gedrag van de cliënt, maar ook in de richting van het aanvaarden van de (onbewuste) visie van de therapeut, dat problemen begrepen en opgelost dienen te worden op een Westerse, zelfredzame wijze. De vraag wordt gesteld of therapie niet de voorkeur geeft aan een dergelijke visie op persoonlijkheid, hoewel ook vastgesteld wordt dat sommige therapeuten dit soort individualisme proberen te vermijden.

Maar het discours van de therapeut kan enkel effect sorteren indien de cliënt zich dit ook tot op zekere hoogte eigen maakt. Hoofdstuk 5 onderzoekt een geval van boulimie, waarbij de aanvankelijke weigering van de cliënt om haar eetgewoontes op een psychologisch 'juiste' manier te interpreteren uiteindelijk overwonnen wordt door subtiele therapeutische herinterpretaties. Het is duidelijk dat de cliënte zich uiteindelijk bepaalde aspecten uit het discours van de therapeut eigen maakt tot ze zichzelf, ondanks haar aanvankelijke weerstanden, in een specifieke psychologische betekenis als een boulimiepatiënte kan herkennen. De combinatie van primaire posities en overredingskracht veroorzaken zo een verschuiving in haar subjectiviteit. Tijdens het proces worden alternatieve verklaringen, zoals die van de cliënte zelf of van het feminisme, ondermijnd als mogelijkheden voor het begrijpen van haar gedrag. Het is opmerkelijk dat de kritiek die de cliënte – door haar weerstand – zou kunnen hebben op de therapie en de therapeut, zodanig verborgen worden dat haar weigeringen eerder in een psychologisch dan een interpersoonlijk of politiek discours gereconstrueerd worden. Therapie wordt door ons beschouwd als één van de lokale situaties waarin strategische verbanden tussen concurrerende discours gelegd kunnen worden. De cliënt en de therapeut worden daarbij ongewild als politieke deelnemers gepositioneerd.

Als tegengewicht voor de voorgaande discussies over therapie als een kennis/machtsnetwerk, onderzoekt hoofdstuk 6 de beweringen van Anderson en Goolishian dat ze macht hebben overwonnen door 'niet weten'; door macht en kennis los te koppelen. Analyse van een sessie van Anderson onthult dat ze zich in die lokale situatie verlaat op speciale gesproken conventies om een illusie van therapeutisch gelijkheid te scheppen. Inderdaad: de gedisciplineerde poging van Anderson om macht te vermijden wordt het meest overtuigende argument voor de aanhoudende aanwezigheid van macht in de ontmoeting. Macht wordt niet overwonnen, maar kan verborgen worden door de theoretische claims van deze praktijkbeoefenaars.

In hoofdstukken 7 en 8 verplaatst de focus zich van de lokale ontmoeting naar de mogelijkheid van een kritische therapie: een praktijk die de bestaande maatschappelijke machtsverhoudingen eerder uitdaagt dan zich eraan conformeert. Vroegere discussies over de neiging van therapie om sociale en politieke factoren te verbergen door haar steun aan een individualiserend discours en het ondermijnen van alternatieven hiervoor (zie vooral hoofdstukken 4 en 6) worden hier relevant, terwijl benaderingen bekeken worden die 'het persoonlijke politiseren'.

Hoofdstuk 7 bespreekt het standpunt van Habermas dat psychoanalyse een kritische en "emancipatorische" praktijk is die mensen bevrijdt van de storende effecten van macht. Habermas situeert zijn kritiek echter in een externe relatie tot machtssystemen, wat problemen van idealisme en autoritarisme creëert. Een

alternatieve zienswijze op kritiek wordt te berde gebracht, waarin gesteld wordt dat kritiek fundamenteel inherent is aan machtsdynamieken. Het is op deze basis dat psychoanalyse als kritiek moet beschouwd worden. Haar neiging – hoewel niet universeel – om interpersoonlijk conflict naar de intrapsychische ruimte te verplaatsen, ondermijnt haar capaciteit om adequaat aandacht te hebben voor weerstanden en de hieraan inherente kritieken te aanhoren. Dat houdt in dat – net zoals Habermas' visie op kritiek – psychoanalyse zichzelf eerder in een externe dan in een interne relatie dreigt te verhouden tot de machtsrelaties waarmee ze vergroeid is. Ze probeert boven de macht te staan. Dit ondermijnt haar mogelijkheid om als kritiek te functioneren. De psychoanalytische theorie vertoont echter elasticiteit en is in de loop der jaren gebruikt om een veelheid aan contrasterende doelstellingen te ondersteunen. Dit suggereert dat psychoanalyse principieel ook gebruikt kan worden om bestaande machtsverhoudingen ter discussie te stellen. Dit hoofdstuk beweert echter dat indien psychoanalyse echt kritisch wilt zijn, zij eerder een strategische dan een neutrale, waarheidszoekende oriëntatie dient in te nemen.

Het fundamentele probleem met kritische benaderingen, zoals beschreven in hoofdstuk 7, wordt diepgaander besproken in hoofdstuk 8. Kritische therapieën (hierbij wordt het voorbeeld van de 'narratieve therapie' onder de loep genomen) lopen het risico geïncorporeerd te worden in politieke strategieën die in de maatschappij teruggevonden worden. Zij zijn net zo vatbaar voor maatschappelijke machtsdynamieken als hun cliënten. Zoals duidelijk aangetoond in de discussie van hoofdstuk 7 over de meer conformistische elementen van de psychoanalyse, worden kritisch georiënteerde technieken en concepten gemakkelijk gerecupereerd en gestuurd in de richting van het ondersteunen van de maatschappelijke praktijken die ze net moesten uitdagen. Als antwoord op deze dreiging van recuperatie, stel ik de tactiek van 'transversale weerstand' voor, die inhoudt dat uit diverse therapieën de verschillende weerstanden tegen algemeen aanvaarde machtsbronnen voorlopig gebundeld worden. En samen met respect voor de particuliere therapeut-cliëntrelatie wordt een strategie van transparantie met betrekking tot politieke interesses aangeraden als een ethische voorwaarde voor kritische therapieën.

Hoofdstuk 9 integreert de voorgaande discussies door de vier vragen te behandelen, die aan het begin van deze thesis werden voorgelegd. Een poging wordt gedaan om de fundamentele sociale en politieke aard van de therapeutische praktijk te belichten, ten eerste door het voorstellen van een hypothese van een vier-stappen sequentie die personen omvormt tot een positie van cliëntschap (voornamelijk gebaseerd op hoofdstukken 2, 3, 4, 5 en 6) en ten tweede door een beschrijving voor te stellen van de plaats van therapie in de machtscirculatie in de maatschappij (afgeleid uit alle hoofdstukken, maar vooral uit hoofdstukken 7 en 8). Beperkingen van de studies worden hier uiteengezet, samen met mogelijkheden voor verder onderzoek en theoretische ontwikkeling.

PUBLICATIONS

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Chapter 2 Guilfoyle, M. (2002) Power, knowledge and resistance in therapy: exploring links between discourse and materiality. *International Journal of Psychotherapy, 7 (1),* 83-98. Parts reprinted by permission of EAP (European Association for Psychotherapy), Vienna. www.europsyche.org *

Chapter 3 Guilfoyle, M. (2006). Using power to question the dialogical self and its therapeutic application. *Counselling Psychology Quarterly, 19 (1),* 89-104. Parts reprinted by permission of Taylor and Francis, Oxfordshire. www.tandf.co.uk/journals *

Chapter 4 Guilfoyle, M. (2002) Rhetorical processes in therapy: the bias for self-containment. *Journal of Family Therapy, 24 (3),* 298-316. Parts reprinted by permission of Blackwell Publishing, Oxford. www.blackwellpublishing.com *

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* Chapter closely based on published article

** Parts of article incorporated in chapter

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CURRICULIM VITAE

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