DOCTORAL THESIS

Exploring psychotherapists experience of medical model thinking in the settings of primary care and private practice – a small scale study

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Exploring psychotherapists experience of medical model thinking in the settings of primary care and private practice – a small scale study

by

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Contents

Abstract

This small scale research study explores psychotherapists' experience of medical model thinking on their practice delivered in the two separate settings of GP surgeries and private practice. The study's key philosophical theme is the difference between modern and postmodern perspectives and how they might manifest themselves in social practices (such as medical interviews), knowledge creation and the practice of psychotherapy. The researcher locates the concepts key to the research in existing literature in terms of theory, research studies and their historical development – this latter being in support of the use of a Foucauldian discourse analytic method which is selected as that which best supports a social constructionist, postmodern approach to research. Parker's method of using the research interview as a text-in-progress is explained and implemented, with eight participants being interviewed twice by the researcher. A discourse analytic framework which draws on defined theoretical resources was applied. The findings from the two part study show that for those participants working in primary care the GP/patient relationship has at least four key impacts on psychotherapy delivered in that setting and that for those working in a private setting it is through their relationships with individual GPs and psychiatrists that participants' have constructed the biggest impact of medical model discourse on their practice and perhaps more importantly on their clients. Links are made to the literature reviewed concerning notions of the power of doctors and ideas for future research focused on the prevalence of 'splitting' in the UK are discussed. The researcher concludes with some thoughts about the fact that whilst the medical models' invisibility and taken-for-granted nature for participants working within a primary care setting was more severe than expected, it was discursively constructed as having less of a wide-ranging impact on the participants in private practice. The importance of remaining awake to the influence of the medical model is discussed particularly during a cultural moment

dominated by modernist approaches to notions of research and increasingly, practice.

Chapter 1: Introduction

In this introduction the researcher will describe how the idea for a study into psychotherapists' experience of medical model thinking working in different settings first emerged and was subsequently developed. Some philosophical ideas central to the research as a whole are introduced and the chapter is concluded with an overview of the structure of the thesis.

1.1 The Question

The idea for the initial focus of this research first emerged through the researchers' experience in working as a trainee therapist in a GP surgery. The researcher was initially very aware of the physical aspects of the medical setting – working in the surgery building itself, using a room often used by GPs full of medical paraphernalia (trying to hide as much as possible of it before receiving a client) and using a computer system which described the days appointments as the researchers' 'clinic'. Over time the researcher became more aware of some more subtle aspects – the way some clients expected them to understand the effects of the drugs they had been prescribed, being quick to place them in the role of expert to whom they should describe their symptoms in order that help may be given more effectively "rather than just sit here and cry" (verbatim). To the researcher as a therapist whose work is influenced by elements of Rogers, existentialism and other more postmodern ideas within what has been called a post-existential cultural moment (Loewenthal, 2011), these expectations seemed to be coming from a very different place philosophically and inevitably became part of the work of therapy itself, sometimes explicitly, always implicitly.

The researcher therefore became interested in exploring other therapists' potential experiences of the medical model, starting with those also working in this type of setting and so conducted an initial study into the potential impacts on psychotherapy

delivered in a primary care setting arising from the patients' relationship with the GP. (This specific interest had been piqued not only by how some clients expressed their expectations when starting counselling, but also by how some GPs spoke of their work when 'off-duty' in the staff room at the surgery.) In essence the first part of the study asked whether there is something about the way GPs and their patients interact inside a medical discourse that is then transmitted or carried into the counselling relationship.

As will be discussed in more detail in chapters four and five, amongst the findings of this initial phase of research was the notion that regardless of their original theoretical training, the language and ideas expressed by the participating therapists reflected core elements of medical model thinking. The completion of the first phase of empirical research coincided with the researcher setting up their own private practice which gave rise to a growing personal awareness that even in this setting the medical model's influence remained very much in evidence in a variety of ways (including, for example, the requirement of most third party payers to provide a 'diagnosis' and 'treatment plan' on their forms, or the need to specify what 'conditions' you offer help with when advertising in certain therapeutic directories). This experience confirmed the idea of focusing the second half of the two-part study on an exploration of psychotherapists' experience of the influence of a medical model discourse in the explicitly non-medical model setting of private practice. Whilst the researcher recognises the difficulties with comparing or generalising findings from any studies (let alone two such small scale studies), they were interested to see what picture emerged of therapist's experiences from the different settings in terms of areas of commonality and difference.

The first part of the study was conducted using the title; "*Is the medical model infectious? How, if at all, is psychotherapy provided in a GP surgery affected by the*

relationship a patient has with their GP? It is important to note that the use of the term 'medical model' in this question refers to the dominant conceptual model used in *medicine* (as opposed to the medical model as applied to psychotherapy). Of necessity in the second part of the study, "*Exploring the influence of the medical model discourse on psychotherapists working in private practice"* the concept of the medical model discourse is broadened to consider how it has been used over time to understand emotional distress (also known as psychopathology) in both medicine and in psychotherapy. The two studies were conducted over a period of three years.

Whilst it was not the intention of the researcher to test a particular hypothesis but rather to explore other therapists' accounts of their experiences, the researcher has subsequently recognised that the wording of the questions used in both parts of the study has implied that it might be *possible* to discern the impact of the GP/patient relationship or the influence of the medical model from all the other influences on a therapeutic encounter and that the world works in such a simple cause and effect way. These issues stem from a perceived philosophical conflict which underpins both the question itself and the choice of how the research would be conducted. In essence, the idea for the research has emerged from a perceived philosophical difference between the position of the therapist/researcher (postmodern) and that of the GP setting and the wider dominant cultural medical discourse (modern). What follows therefore is a brief outline of these ideas in order to contextualise the study as a whole.

1.2 Conflicting philosophies – modernism v postmodernism

As is more explicitly discussed in chapter two, 'the medical model' in medicine is a short hand term used to describe the dominant Western approach to professional medicine which is underpinned by a modernist understanding of the world. Leonard (1997:5) describes modernism "as having been founded intellectually on a belief in

the power of reason over ignorance, order over disorder and science over superstition as universal values with which to defeat the old orders". Ontologically, reality is assumed to be "objective and singular, apart from the researcher" (Cresswell, 1994:5). There is a fundamental belief in the idea "of progress as possible, probable or necessary" (Lyotard in Leonard, 1997:7). In terms of language, modernity's knowledge claims "are based upon the idea that language performs the function of *representation …* Things are named as a way of grasping hold of reality" (Leonard, 1997:9). The individual "…the subject of modernity…rests upon an assumption of the existence of an essential, self-directing individual person" (Leonard, 1997:33). This was partly based upon Descartes (1982 (1697)) work in which he had "enthroned the thinking Subject as the arbiter of certain knowledge, when he famously declared, *'cogito ergo sum*' or 'I think therefore I am'" (Heartfield, 2006:27). This view gave "primacy to consciousness and reason" and "postulated the human being as a mind free to ponder an 'outside' world, a mind housed in a machine-like body" (Loewenthal & Snell, 2003:3) assuming a fundamental difference between these kinds of matter (in a doctrine known as 'mind-body' or Cartesian 'dualism'). In combination in modernism there is a view of an independent reality which is accurately represented by and described through language and in which causes and effects can be measured and categorised in objective experiments by autonomous individuals.

In contrast, postmodernism questions the assumption of an independent objective reality and instead considers how reality is "subjective and multiple" (Cresswell, 1994:5). Social constructionists argue that "through deconstruction we are able to see our knowledge and beliefs as historically and culturally specific products" (Leonard, 1997:23). As social constructionism will be referred to throughout this piece of research, the researcher will briefly explain that, according to Gergen (1985:266-8) "Social constructionist inquiry is principally concerned with explicating

the processes by which people come to describe, explain or otherwise account for the world (including themselves) in which they live" and highlights the fact that "descriptions and explanations of the world themselves constitute forms of social action". Critically in postmodernism, through the ideas of Saussure and Lacan, language itself is seen as "fundamentally a social institution, it precedes us, we are born in to it…words, in other words, also speak us" (Loewenthal and Snell, 2003:65). Meaning is seen as highly subjective and transient and in place of the certainties of modernism, "Uncertainty about the future… is the only thing we can be certain about" (Leonard, 1997:27). The autonomous subject of modernism is replaced in postmodernism by the heteronomous subject – the idea that humans are always 'subject to' - to social forces, the unconscious, the power of others and ultimately and most simply according to Levinas (1989), we are subject to and responsible for the Other. In summary, from a postmodern view, reality is subjective, culturally and historically constructed and mediated through language in which meanings can slip and slide and as a result the basis of knowledge itself is brought into question.

In terms of the research questions asked, therefore, it might be regarded as overly simplistic to assume that it might be possible for a therapist to isolate impacts from either the GP/patient relationship or a concept as broad as a medical model discourse - "the therapeutic relationship is an interpersonal and dialogical process and a complex holistic phenomenon that cannot be dismantled into component, linear causal parts" (Schmitt Freire 2006:328). This issue will be discussed further in chapter five.

As these ideas have implications not only for the practices of medicine and therapy but also for the nature of research as a knowledge creating enterprise, they are explored in more detail as part of a review of the literature relevant to the question and in relation to the selection of the chosen methodological approach.

The researcher will now briefly explore what is meant by Foucault's notion of discourse as it is fundamental to this thesis in terms of both the methodology used and the entire frame of the second part of the study.

1.3 Foucault and Discourse

Whilst Foucault rejected the label of postmodern for his work he did define it as a critique of modernity (Lupton,1987) and many of the range of possible components of postmodern thinking outlined above can be found in his ideas.

Foucault (1969:121) defined a discourse as being "constituted by a group of sequences of signs, in so far as they are statements …the law of such a series is…a discursive formation". Leonard (1997:2) sees discourses in this sense "as linguistic systems of statements through which we speak of ourselves and our social world". Parker et al (1995:10) summarise that "Foucault's work has been invaluable in drawing attention to the way language is organized around different systems of meaning which offer positions of power to certain categories of people and disempower others. These systems of meaning are *discourses*." (Parker et al, 1995:10)

Using an approach referred to as genealogy, which "disturbs formerly secure foundations of knowledge and understanding" (Hook, 2005:8) Foucault's objective in his work was to "create a history of the different modes by which, in our culture, human beings are made subjects" (Foucault, 1982:208) and he argued that certain dominant discourses have the power to constitute, to bring into being, certain objects and subjects. "For Foucault, the subject is constituted through discourse rather than having a prediscursive existence" (Bunton & Peterson, 1997:3). The notion that seeing the world through a discursive lens potentially signals the death of the subject is an important idea that will be returned to in chapters two, three and five.

Foucault therefore attempts to deconstruct “such unities as ‘science’ or ‘literature’” and to “tear away from them their virtual self-evidence, and to free the problems that they pose; to recognise that they are not the tranquil locus on the basis of which other questions may be posed, but that they themselves pose a whole cluster of questions” (Foucault, 1969:28-9). One such apparent unity he saw was medicine. In the Archaeology of Knowledge (1969) Foucault lays out his epistemology, seeking to explain what constitutes such discursive unities – whilst the definitions above focus on language and what it *does* in constituting objects and subjects, the discursive field he describes also includes the broadest context in terms of who is speaking, from what institution, with what authority based on what knowledge? Clinical medicine, therefore, must be regarded as “the establishment of a relation, in medical discourse, between a number of distinct elements, some of which concerned the status of doctors, others the institutional and technical site from which they spoke, others their position as subjects perceiving, observing, describing, teaching etc” (Foucault, 1969:59).

It should also be noted that dominant discourses are as important in terms of what they do *not* say as in what they *do*: “The manifest discourse, therefore, is really no more than the repressive presence of what it does not say; and this ‘not-said’ is a hollow that undermines from within all that is said” (Foucault, 1969:28). With particular reference to the discourse of madness he suggests that “the constitution of madness as mental illness at the end of the eighteenth century, affords the evidence of a broken dialogue…and thrusts into oblivion all those stammered, imperfect words…in which the exchange between madness and reason was made. The language of psychiatry, which is a monologue of reason about madness, has been established only on the basis of such a silence. I have not tried to write the history of that language, but rather the archaeology of that silence” (Foucault, 1967:xii). As he later went on to say in 1969, in attempting any historical analysis of the development

of a discourse, the question thus becomes “how is it that one particular statement appeared rather than another?” (Foucault, 1969:30).

It is imperative, therefore, to pay attention to the broader discursive context of any one discourse. As Foucault (1969:74) summarises; “Well to the fore is the role played by the discourse being studied in relation to those that are contemporary with it or related to it. One must study therefore the *economy of the discursive constellation* to which it belongs.” In chapter two, therefore, it will be important for the researcher to examine the literature regarding the relationship between the discourses of the medical model in medicine, psychiatry and psychotherapy.

Finally in this chapter, the researcher will outline the overall structure of the rest of the thesis.

1.4 The structure of the thesis

In chapter two the researcher defines the key terms used in the questions for each part of the study, explains the rationale for the selection of five key conceptual areas to form the content of a literature review and presents the findings of that review. The areas covered are as follows; first, the medical model in medicine especially as it is found in primary care, including the idea of this as a *discourse;* second how this discourse has impacted the development of the GP/patient relationship; third, models for understanding human distress, focusing on evolving versions of the medical model, which includes how the doctor/ patient relationship has developed within the field of ‘mental health’ and how it has historically intersected with the practice of psychotherapy; fourth, medical model discourses within psychotherapy itself including key alternatives proposed at a meta-theoretical level and finally a summary of literature which offers postmodern critiques of the medical model in all its guises. The literature review includes both theory and research and, in support of the method chosen for the research, a brief historical analysis of each concepts’ development.

The third chapter is devoted to exploring the possible choices of methodology and how the chosen method was then implemented for the study. The researcher concludes a case for looking to qualitative rather than quantitative research options and from those describes the rationale for selecting a version of Foucauldian discourse analysis. The researcher then provides an outline of the specific methodology selected together with a description of the steps actually adopted for the research (from Parker, 1992, 2005).

In order to analyse data generated through Parker's methodology, the researcher was required to identify the theoretical resources which would form the basis of an analytic framework. These were identified as being; Foucault's ideas on power and its relationship to knowledge and how this manifests itself in medical practices and institutions; the presence or absence of medical model language and discourses in relation to therapy and notions of autonomy and heteronomy as expressed in humanistic and postmodern literature.

Those who support postmodern, ideological research in fact place importance on the twin hopes that research can be a catalyst in "increasing consciousness about issues of power and oppression, and—for the ideological and critical perspectives in particular—the potential of the research to create change" (Morrow, 2005:545). The selection of the method used in the research has very much reflected and reflexively influenced this awareness of the potential of research to effect change.

In chapter four, the stages of the analysis are made clear and presented alongside the discursive findings which are, for part one, grouped into four sets; one in terms of the therapeutic setting, two competing sets of "official" discourses and a set of "unofficial" discourses. For the second part of the study the findings are grouped into three sets; again one in term of the setting and two competing sets of discourses and their associated subject positions.

Finally, in chapter five, the researcher reflects on the research as a whole and offers a critique which aims to highlight its strengths and weaknesses. This encompasses a more detailed discussion of the findings in terms of how they relate to the literature reviewed in chapter two, a review of the method used, what has been learned by both the researcher and the participants and concludes with some ideas for further research.

Having given a brief introduction to the research study and set out the structure of the thesis the researcher will now turn to an examination of the literature relevant to this research.

Chapter 2: Literature Review

This chapter has two main purposes – the first is to define the key terms used in the research question - as words are often ambiguous it is important in any piece of research that the researcher clarify their understanding and usage of particular terms. The second is to give an overview of the existing literature relevant to the research conducted. The researcher recognises the breadth of the subject under scrutiny and has therefore targeted the most relevant areas for a systematic review of the literature in terms of both theoretical writings and research studies undertaken.

It is also important to note that the literature review has necessarily been influenced by Foucault's notion of discourse for two reasons; first the research question for the second part of the study is specifically framed in terms of this idea; second Foucauldian Discourse Analysis is the chosen methodology for both parts of the study (the rationale for which and detail of is covered in chapter three). According to Parker (2005:91), "the preparation for a piece of qualitative research using discourse analysis needs to include historical analysis of how the forms of language in question have come to organize certain social bonds…so that analysis of language in a piece of text does not treat it as if it came out of nowhere (and) …so that the text is put in the context of actual 'social bonds' or power relations". The researcher therefore attempts to locate the key concepts to this research in terms of both theory and research *and* trace their development through an (albeit brief) historical analysis.

2.1 Definition of terms

As this research has been operationalized as two studies, the researcher has included a definition of terms for each one. For the first study, which asked the question "*Is the medical model infectious? How, if at all, is psychotherapy provided in a GP surgery affected by the relationship a patient has with their GP?* "the researcher defines the key terms in the following way:

(i) **The medical model**: refers to the dominant 'professional' biomedical approach to Western medicine as it might be described in the practice of medicine (including biological psychiatry) as opposed to how it might be applied to the field of psychotherapy. A distinction is drawn, however, between the medical model and the wider model of science in which it is set.

(ii) **Infectious** is used deliberately in two ways – most obviously in terms of an "emotion, opinion, etc: likely to be passed on to others" (Chambers Dictionary, 2010), but also in a deliberately ironic sense in relation to the medical model, the idea of a disease or person infected with a disease that "may be transmitted" to others.

(iii) **Psychotherapy** for the purposes of this report, means both counselling and psychotherapy and the term therapist has been used throughout to denote a psychotherapist or counsellor (in line with BACP's response to the HPC consultation process (Aldridge, 2010)).

(iv) **A GP** denotes a General Practitioner within the NHS in the UK. The Royal College of General Practitioners definition is that "(GPs) are best defined by the unique nature of the doctor-patient relationship"(www.RCGP.org.uk)

(v) **A surgery:** To the dictionary definition of this as "the place where a [GP] sees their patients and carries out treatment" (Chambers Dictionary, 2010), the researcher adds 'and where a patient may access a variety of services which their GP may refer them to, including therapy'.

(vi) **"The relationship a patient has with their GP"** is intended to imply not only singular relationships of one patient to one GP, but also recognises that a patient may routinely see several GPs including locums – by extension therefore it is a relationship a patient has with any GP and with GPs *in general* (it should be remembered that psychotherapists are also GP patients in their own right). When a patient walks into a consulting room to see a GP for the first time they are not doing so free from any expectation or

assumption. As Willig (2008:113) explains “from within a biomedical discourse, those who experience ill-health occupy the subject position of ‘the patient’, which locates them as the passive recipient of expert care within a trajectory of cure”.

For the second study, ‘*Exploring the influence of the medical model discourse on psychotherapists working in private practice*’, the researcher defines the key terms in the following way:

(vii) **Influence:** is used in the sense of ‘the power of producing an effect, especially unobtrusively…; domination, often hidden or inexplicable;’ (Chambers Dictionary, 2010)

(viii) **The medical model discourse**: this is intended to refer to the discourses of medical models used in both medicine (see above) and in psychotherapy (see below), where a discourse is used in the Foucauldian sense as ‘the way language is organized around different systems of meaning which offer positions of power to certain categories of people and disempower others’ (Parker et al, 1995:10). What is important therefore is how things are *spoken* of, who by and from what position (see also chapter one). In terms of content, briefly, “in its clinical mode, this dominant model of medical reasoning implies: diseases exist as distinct entities; that those entities are revealed through the inspection of “signs” and “symptoms”; that the individual patient is a more or less passive site of disease manifestation; that diseases are to be understood as categorical departures or deviations from “normality”” (Atkinson, 1988:180). The medical model discourse in psychotherapy alternatively is essentially formed around an analogy, “a descriptive schema borrowed from the practice of medicine and superimposed on the practice of psychotherapy” (Elkins, 2009:67-71). An exploration of the subtleties of these discourses forms a significant part of the review of literature to follow.

(ix) **Psychotherapist:** see (iii) above

(x) **Private Practice:** For the purposes of this research this term refers to the work of a psychotherapist who is primarily self-employed i.e. not substantially employed as a therapist by any organisation (particularly medical) nor required to adhere to any ways of working other than those a) associated with accrediting bodies ethical frameworks or b) they have chosen for themselves.

Having defined the terms of the research question, the researcher will now present the findings from the review of the relevant literature.

2.2 An overview of the literature

In conducting the literature search the researcher devised a search plan based on a structure recommended by the BACP (Brettle, 2008) and which used a combination of data sources, including (but not limited to) the on-line databases PsycINFO, PsycARTICLES, PsycBOOKS and on-line e-journal archives, most notably the BMJ Journals Collection, SAGE Journals on-line and Informaworld (Routledge). In addition, reference lists from relevant articles proved to be significant sources of leads for further reading.

The literature review considers what has already been written about the medical model and its manifestations in doctor / patient and client / therapist relationships. It covers five key areas and as discussed literature regarding theory, research and the historical development of the concept are covered in each section;

(i) the medical model in medicine, focusing especially on primary care

(ii) how this discourse has impacted the development of the GP/patient relationship (in order to consider how the power dynamics inherent in that relationship might be carried into psychotherapy)

(iii) literature detailing the history of models for understanding human distress (also known as psychopathology), focusing on evolving versions of the medical model, which includes how the doctor/ patient relationship has developed within the field of 'mental health' and how it has historically intersected with the practice of psychotherapy

(iv) literature regarding medical model discourses within psychotherapy itself including key alternatives proposed at a meta-theoretical level, in order to further understand what has been written about the range of possible ways in which the medical model may be experienced by participants

(v) Finally, a summary of literature which offers postmodern critiques of the medical model in all its guises is presented. This has been included in order to contextualise participants' possible interpretations of their experiences of the medical model and because as we have seen in chapter one, the entire study is framed in terms of a perceived conflict between modern and postmodern approaches played out in the surgery and in the therapy room.

2.2.1 The medical model in medicine

This section will consider the literature concerning the medical model in medicine (or the biomedical model) and its relationship to science for two reasons; the first is to understand how patients may experience their interactions with GPs and how this might subsequently influence therapy; the second is that this will then contextualise notions of the medical model used in both in psychotherapy and in conceptions of human distress more broadly.

It has become apparent during the literature search that the concept of a homogenous 'medical model' in medicine is an illusion (Atkinson; 1988, Helman; 1994, Siegler & Osmond; 1974). In addition, whilst in the sociological and anthropological literature the dominant discourse surrounding 'biomedicine' as the

professional, scientific, modernist face of health care is discussed at length, there are also those discourses which focus on other significant elements of the social provision of health care. These include the 'popular' sector, which includes the family as the most primary arena for health care delivery and the 'folk' sector, which is comprised of other non-professional health care providers (Helman; 1994, Engel; 1977, Pilgrim and Rogers, 1993). In fact Engel (1977:319) contends that "the biomedical model is [also] now the dominant folk model of disease in the Western world". The idea that Western culture has become a "psychiatric society" is also noted by Handy (1987:165) and as Parker et al (1995:70) note "It no longer seems sensible to talk of 'professional' and 'lay' concepts as separate things since the distinction between them is not so much in the kinds of discourse used by speakers but rather the position from which they speak". It was therefore recognised by the researcher that this may add to the problematic task (in the first part of this study) of making a distinction between impacts on the therapeutic encounter stemming from the GP/patient relationship and the patient's own internal conceptions of the practices of medicine and counselling, as they both may be grounded in the biomedical model. This idea is in fact the reason for pursuing the second part of the study which explores the influence of the medical model beyond the medical setting.

Amongst those writers who focus on the dominant 'professional' biomedical approach to Western medicine, Siegler and Osmond (1974:3), suggest that" The division of medicine into *clinical* medicine, *public health* medicine, and what we have called *science* medicine is extremely old". Briefly, public health medicine has as its goal "the prevention of disease and the promotion of health for a given population" (Siegler & Osmond, 1974:120), "the goal of the scientific medical model is…to acquire knowledge about human anatomy and physiology and about the cause, prevention and treatment of diseases" (Siegler & Osmond, 1974:123) whilst clinical medicine is a *practical* art, the goal of which is to "treat patients for illnesses; restore them to

health if possible; otherwise prevent illness from getting worse. Reduce blame by conferring [the] sick role" (Siegler & Osmond, 1974:18). The theoretical literature primarily considered here is that which focuses on the third of these models in terms of its clinical manifestations, philosophical underpinnings in science (drawing on ideas from the scientific medical model), and a Foucauldian genealogy of how it has come to exist in its current form (in terms of practice, power and knowledge).

As referenced in the definition of terms, Atkinson's (1988:180) definition focuses on this model of clinical medicine in concluding that "In its clinical mode, this dominant model of medical reasoning implies: diseases exist as distinct entities; that those entities are revealed through the inspection of "signs" and "symptoms"; that the individual patient is a more or less passive site of disease manifestation; that diseases are to be understood as categorical departures or deviations from "normality"". In his much referenced paper Engel (1977:322-3) adds that "The biomedical model...encourages by-passing the patient's verbal account by placing greater reliance on technical procedures and laboratory measurements". This is also described by Good & Good (1981) and Helman (1994:103) who summarises that ""Increasingly modern medicine has come to rely on diagnostic technology to collect and measure clinical 'facts'". Gordon (1988:25) goes on to note the bias inherent in this model towards action; "To "move" nature, one must not "think so", one must "do so", that is, manipulate it physically". In combination, we arrive at an active, modernist, clinical model consisting of inspection, investigation, diagnosis, and treatment aimed at the cure or relief of disease or injury.

The role of science was central to the rise of modernism (Gordon, 1988; Lupton 1987; Parker at al, 1995) and according to Foucault (1973:197) medicine played a key part in the development of the necessary detachment required for the role of the observer / scientist. He argued that "from the integration of death into medical

thought is born a medicine that is given as a science of the individual". He went on to explain that "Western man could constitute himself in his own eyes an as object of science, he grasped himself within his language, and gave himself, in himself and by himself, a discursive existence, only in the opening created by his own elimination" (Foucault, 1973:196-7).

As Heartfield (2006:23) notes "Foucault's point is that the human sciences did not discover Man, as an empirical fact, waiting to be investigated. Rather, he argues, these very scientific discourses themselves brought Man into being". Foucault therefore argues that medicine was of great importance to the constitution of the sciences of man, an importance that was "not only methodological, but ontological, in that it concerns man's being as object of positive knowledge". This idea also surfaces in Armstrong's (1997:21) summary that the notion of the individual as a container of disease; "is one form in which individual identity begins to make its appearance on the Western stage…the deployment of the clinical gaze forms an integral part of our individual experience and identity".

This is potentially an important idea to recognise in that some later thinkers (Ahn & Wampold, 2001; Kihlstrom, 2002; Reznak, 1991) have suggested that scientific method can be appropriately used in psychotherapy without needing to align itself with biomedical thinking. If, however, there is something inherent in the idea of studying the self as object that has been derived from medicine, can scientific method ever escape the influence of a medical model? Is the gaze part of science? (The notion of the clinical gaze will be returned to in the next section as part of a consideration of power in the consulting and therapy rooms).

Taylor (1985:4) also states that "behind and supporting the impetus to naturalism [or "science"] stands an attachment to a certain picture of the agent…It shows us as capable of achieving a kind of disengagement from our world by objectifying it". Ideas

of how these assumptions impact the GP / patient relationship will be discussed later in this chapter. This idea of disengagement is echoed by Gordon (1988:32): "the western philosophical and scientific traditions have long assumed that detachment provides the purest window to truth…Thus to arrive at real knowledge we must alter ourselves – move back, distance ourselves from values, local bias, and particular interest by taking a universal standpoint, one which is disengaged from everyday life. *Knowing* then is distinct from *being* according to naturalism". These distinctions are highly relevant in considering how doctors interact with their patients, both in terms of relational distance and expectations in terms of individual responsibility.

Gordon adds that "The history of medicine is frequently understood to be a cumulative progression towards the unfolding of truth about nature's diseases. The belief in primarily one truth, which is best captured in the neutral language of numbers, is strong" (Gordon, 1988:29). Ideas about the role of numerical evidence in the doctor / patient interview are explored in the next section which considers the literature relating to the relationship between GPs and their patients.

2.2.2 The GP / Patient Relationship

For the purposes of this study the researcher is interested in understanding what has been written and researched about the nature of this relationship specifically in connection with the medical model and / or the medical discourse. Are there any potential impacts on the patient in terms of how they might be encouraged to be and act? Are there general expectations of doctors that might get carried through into a subsequent relationship with a counsellor?

The researcher has therefore conducted a literature review within this definition and has found a combination of both theoretical writings and research studies from a variety of fields, most notably sociology, medical ethics and psychotherapy. There

appears to be some consensus around how this relationship has developed in the West in terms of models of interaction which are directly related to developments in medicine. Moore et al (2005:182) describe four models starting with the “Paternalistic Model [which] is essentially duty based, with the physician's role emphasizing four fundamental principles: *beneficence, fidelity, nonmaleficence,* and *confidentiality*”. This seems broadly comparable with Shorter’s (1991:29) “traditional doctor” and both authors suggest this model was dominant until the 1920’s and as Moore et al (2005:182) explain, rested on the fundamental principle of “*guardianship* in which the physician acts in what he or she judges to be the patient's best interest largely independent of others' input”. The patient is “expected to answer physicians' questions honestly and accurately and to comply with physicians' treatment recommendations, even if they disagree with them”.

Moore et al (2005:182) then go on to describe the emergence of an “Expert” model which while encompassing the same four principles of the Paternalistic model saw “an emergent emphasis on physicians' education, technical knowledge, and professional certification”. This is paralleled by the model of the “modern doctor” whose new found expertise rested on developments in anatomy (Shorter, 1991). Interestingly, Engel (1977:320), citing Rasmussen, suggests that “the Church’s permission to study the human body included a tacit interdiction against corresponding scientific investigation of man's mind and behavior” thus helping to firmly establish mind body dualism in Western medicine (an idea which, it is argued by Fratteroli (2001), is becoming increasingly marginalised within biological psychiatry.)

The next major development in the doctor /patient relationship came after world war two with the beginning of the widespread use of penicillin, broad spectrum antibiotics and drugs able to treat inflammation. For Shorter (1991:183) these postmodern

(chronologically speaking) doctors were “imbued with a relentless new enthusiasm about their ability to cure organic disease”. Roter and Hall (2006:4) note this drug revolution “led medicine toward a mainly organic picture of disease, as something to be combated with drugs. The battle lines were drawn between the doctor and the aberrant molecules, and the patient was often left on the sidelines. Thus the world saw the birth of the “biomedical” model of disease and medicine’s diminished interest in the patient’s experience of illness”.

These developments, it is claimed, set in motion two key changes in the context in which the relationship between the doctor / patient is played out – the medical interview: the first was the increase in the use of biochemical tests and their numerical outcomes; second the reduction of the importance of history taking and other forms of communication (Shorter; 1991, Roter and Hall; 2006, Helman; 1994).

The changes to the medical consultation are the subject of much analysis with all the authors concluding that it was at this juncture that the role of emotion and the therapeutic value of attention giving by the doctor were critically deemphasized, certainly in the UK. In his study of medical efficacy, White, as quoted by Roter and Hall (2006:13) maintained that “about a quarter of all benefits to be derived from medical care [should be] attributed to the therapeutic effect of talk”. In decentring the role of communication, therefore, it is argued that significant damage was done to the value of the doctor / patient consultation. Shorter (1991:252) summarises by saying “I am not blaming family doctors for not attempting formal psychotherapy…I am blaming them for ignoring the informal psychotherapeutic power of the consultation itself… the healing power of the consultation lies in the catharsis that the patient derives from telling his story to someone he trusts as a “healer””. This idea would seem to be supported by the literature that has concluded that there is a therapeutic effect created simply by a GP being seen to take a patient’s concerns seriously by

referring them for therapy, regardless of whether that therapy is then taken up (Snape et al, 2003, Munjal et al, 1994). More recent studies have confirmed the value not only that patients place on a trusted, consistent relationship with a GP (Fogarty, 2001; Frederiksen, Kragstrup, Dehiholm, & Lambertsen, 2010; Shaw, Ibrahim, Reid, Ussher, Rowlands, 2009 and Skirbekk, Middlethon, Hjortdahl, & Finset, 2011) and the importance of GPs taking the time to listen and understand the meaning patients place on their experiences,(Jagosh, Boudreau, Steinert, MacDonald & Ingram, 2011; Llorca, 2009) but also the therapeutic value of doing so in terms of patient adherence to treatment recommendations (Stavropoulou, 2011). There are even now studies into the neuroscience behind the effect that the therapeutic relationship can have in its own right (Benedetti, 2011). But perhaps, as Frattaroli (2001:62) suggests, doctors are *attracted* to a more emotionally neutral way of working precisely because the "Medical Model insulates the physician from the anxiety of his own human condition. It emphasises the difference and the distance, between doctor and patient".

Roter and Hall (2006:5) consider the impacts of the changes detailed above on patients and conclude that they "are thought to defend themselves against feelings of overwhelming complexity, demoralization, and helplessness by recourse to idealization or denigration of the physician". Is it possible that this form of defence could be carried into a psychotherapeutic relationship?

Stein (1985:4) considers the doctor / patient relationship specifically from a psychoanalytic viewpoint in great depth. The role of the unconscious also appears to be supported by the suggestion from Goldberg and Bridges, cited by Herrington at al (2003:265) that "patients might be conditioned to under-report emotional distress due to the historical stigma of psychological problems; unlike physical problems where the patient feels that a pain is real. They also suggest that this may cause patients to unconsciously somatise their psychological problems". Lipsitt (2005:1) argues that

such patients are “perhaps the most difficult challenge for the primary care physician. Physicians who are trained essentially in the biomedical model feel ill-equipped to diagnose, manage or treat these patients”.

The relationship between a GP and their patient and in particular how GP’s might approach such patients was something explored in great detail by the psychoanalyst Michael Balint in the 1950’s and 60’s (working with his third wife, Enid, also an analyst). He noted that there was something about the way that a doctor’s own style or personality interacted with his training in medicine that resulted in the development of a unique but fixed way of dealing with patients peculiar to each doctor. He called this the “Apostolic mission or function [which] means […] that every doctor has a vague, but almost unshakeably firm, idea of how a patient ought to behave when ill” (Balint, 1964:216). Whilst his research methodology was not based on a medical model (using group meetings of GPs facilitated by psychiatrists) perhaps inevitably given his training as a biochemist, he framed his underlying question very much in those terms: “Our chief aim was a reasonably thorough examination of the ever changing doctor patient relationship, i.e. the study of the pharmacology of the drug "Doctor"” (Balint, 1964:4). One of the study’s conclusions was that “It was almost as if every doctor had revealed knowledge of what was right and what was wrong for patients to expect and to endure, and further, as if he had a sacred duty to convert to his faith all the ignorant and unbelieving among his patients” (Balint,1964:216) which seems to start to say something about the power relationship involved. Hinshelwood (1997:265) went on to undertake "a full examination of the ethics of influencing another human being” and examines in details the influence of medical ethics on the therapist / analysand relationship. He concludes that whilst there is clearly power involved, “there is a difference between an act of treatment upon a non-consenting patient that overrides his power and autonomy (a psychic act) and an interpretation that directly puts into his hands the wherewithal (a psychic fact) to augment his own

power and autonomy through being more integrated within himself. (Hinshelwood, 1997:2523)

Foucault, who considers how “power is embodied in the day-to-day practices of the medical profession within the clinic” (Turner, 1997:xiv), also seems to be saying something about how the medical discourse operates both consciously and unconsciously, verbally and preverbally: “Clinical experience – that opening up of the concrete individual for the first time in Western history to the language of rationality, that major event in the relationship of man to himself and of language to things – was soon taken as a simple, unconceptualized confrontation of a gaze and a face, or a glance and a silent body; a sort of contact prior to all discourse, free of the burdens of language, by which two living individuals are ‘trapped’ in a common, but non-reciprocal situation” (Foucault, 1973:xiv-xv).

Another commentator, Armstrong (1997:21) adds that “the deployment of the clinical gaze forms an integral part of our individual experience and identity” picking up on Foucault’s belief that, as previously mentioned, “the subject is constituted through discourse” (Bunton and Peterson, 1997:3). The idea that the medical discourse operates preverbally potentially has profound implications for therapy delivered in an overtly medical setting. As Burman and Parker (1993:157) note “although power is certainly (re)produced in discourse, power is also at work in the structural position of people when they are not speaking. Power relations endure when the text stops”.

In an attempt to understand the power of the doctor Siegler & Osmond (1974) develop the notion of “Aesculapian authority” which is a term they ascribe to Paterson (1957) which refers to a particular kind of authority he argued to be possessed by someone perceived as a doctor. This authority is seen to have three components; sapiential authority which “means the right to be heard by reason of knowledge or expertness. Such authority resides in the person and not in any

position that he may occupy" (Siegler & Osmond, 1974:93); moral authority, which is understood as "the right to control and direct by reason of the rightness and goodness according to the ethos of the enterprise" (Siegler & Osmond, 1974:94); and "charismatic authority, the right to control and direct by reason of God-given grace…In Western culture the charismatic element in medicine has to do with the possibility of death and with the impossibility of fully assessing the doctor's knowledge" (Siegler & Osmond, 1974:9). The notion of Aesculapian authority seems to combine elements of both the 'expert' and 'traditional' doctor already described - and it's "clumsy, careless or even downright inept use" is argued to be at the heart of "many of the current dissatisfactions expressed by patients regarding their doctors" (Siegler & Osmond, 174-5). It is argued by Koch & Jones (2010:371) that the difficulty of balancing the professional tradition for emotional distance with a level of personal engagement in order to be effective may contribute to "early physician burnout".

Whilst the power might all seem to be in the hands (or the gaze) of the GP, Truog (2012) argues that recent decades have seen a general increase in empowerment of people generally including specifically the emergence of the concept of patients' rights. In one study by Pilgrim et al (1997), cited in Herrington et al (2003:265) they noted that "Some individuals visit their GP with a formulation of their problems and actively request specific help – the autonomous patient" – however, as can be seen by the sheer range of influences on whether the GP then refers the patient cited in this paper (which usefully summarises all the literature on GP referral), the patient only has the power to ask – whether they receive remains in the power of the GP.

An alternative view can maybe be seen in the conclusions of a survey of counsellors conducted by Aubrey et al. (1997: Conclusion) which included their opinions on patients' suitability for counselling. The most common reasons cited for unsuitability

were: “motivation for therapy, motivation for change and psychopathology”, suggesting that some patients are “sent” for counselling rather than asking for it.

By focusing on the biochemical at the expense of communication, Shorter (1991:217) argues that the doctor is more likely to miss “apparently ‘trivial’ symptoms [which] are often just an excuse allowing the patient to gain his composure in the doctor’s office in order to talk about the real underlying problem, which is often psychological”- the fact that this change has also been accompanied by a perceived increase in the time pressure on the doctor / patient interview is noted by Helman, 1994, Shorter, 1991 and Roter and Hall, 2006. As Siegler & Osmond (1974:200) summarise when considering Paterson’s (1957) ideas “the “art of doctoring” and the “techne of medicine” are the warp and woof of the medical fabric” and the doctor’s ability to weave the two is critical to the success of the medical interview.

In considering further the literature regarding Foucault’s notion of the clinical gaze it is highly relevant to this study in two ways. The first is the idea that as Armstrong (1997:21) summarises “The gaze has been identified by a number of different writers as representing the process through which specific social objects, namely disease categories, come into existence”. Further, it is seen as “a means of bringing into being the subjects ‘doctor’ and ‘patient’” (Lupton, 1987:99).

As Rabinow (1994:xii) noted, Foucault “sought to work at the nexus where the history of practices met the history of concepts”. He therefore placed great importance on the physical location of social practices in their specific institutions – in his deconstruction of the archaeology of medical perception in “The Birth of the Clinic” (1973:89) Foucault notes that during the eighteenth century “the medical gaze was… organized in a new way. First, it was no longer the gaze of any observer, but that of a doctor supported and justified by an institution, that of a doctor endowed with the power of decision and intervention”. The gaze, therefore, is “both a literal description

of social practices and a metaphor for the monitoring and surveillance of subjects undertaken by state apparatus" (Leonard, 1997:43).

This signals the second aspect of the gaze relevant to this study which concerns power: "Foucault saw power as a relationship which was localised, dispersed, diffused and typically distinguished through the social system, operating at a micro, local and covert level through sets of specific practices." (Turner, 1997:xi-xii). Foucault's' ideas on power and knowledge (which he sees as "inseparable" (White and Epston, 1990:21)) are central to his observations on the medical discourse. He sees power as being 'constitutive' – that it has a "role in "making-up" persons lives" and that "rather than proposing that this form of power (power through truth) represses, Foucault argues that it subjugates. It forges persons as "docile bodies"". It is made clear that this is not an intentional subjugation on the part of power hungry medics, but an effect of us all operating in the world of available discourses.

From his work in charting the history of the development of the practices of medicine and psychiatry, it emerges that "power as it operates in the medical encounter is a disciplinary power that provides guidelines about how patients should understand, regulate and experience their bodies" (Lupton, 1987:99). Foucauldian scholars contend that "society is medicalised in a profound way, serving to monitor and administer the bodies of citizens in an effort to regulate and maintain social order as well as promoting good health and productivity" (Lupton, 1987:100). Foucault's work potentially tells us, therefore, about the power relationships that may exist in the modern equivalent of 'the clinic' - GP surgeries and other NHS structures - and how as a result subjects may be constituted.

In the same vein as the calls for an evolution in the medical model (more of which later), the literature which considers the doctor / patient relationship includes a variety of suggestions or hopes for its future development, with various models being

proposed, from the mutuality model in which “each participant brings strengths and resources to the relationship on a relatively even footing” (Roter and Hall, 2006:27) to Moore et als’ (2005:186) partnership model which “emphasizes the physician's interpersonal skills, including empathy and patient education”, also echoed by Aziz, (2009).

So, having gained this view of the current state of the doctor / patient relationship in primary care as it relates to the development of the medical model in medicine, what research is out there about how this might impact the counselling relationship?

The researcher has located two studies that have considered either client expectations of counselling in primary care or the potential impact of the GP / Patient relationship on counselling. The first of these is a qualitative piece of research conducted by Lambert (2007) entitled “Client perspectives on counselling: Before, during and after”. Three of her eight participants were accessing counselling in a primary care setting. Whilst she explored expectations and influences on how clients perceived counselling there was no mention of any potential impact of the GP / patient relationship or the medical model more broadly – and whilst at least two of the participants expressed a desire to be asked more direct questions by their counsellor, this was interpreted as being an “indication of researcher influence on expectation” (Lambert, 2007:109). (This was somewhat understandable as the participant used the research interview as an example but there is no exploration or wondering about *why* the participant had that preference.)

The most pertinent research found, however, was conducted by Cocksedge and May (2006:133-135) who have researched the “role of general practitioners in the referral process” to counselling in primary care. They usefully discuss the different ways in which GPs perceive their motivations in this process from which it might be possible to deduce a range of expectations of both counsellors and counselling that might be

generated in their patients; “Motives reported in making a referral to a counsellor included giving patients the best possible care, sharing the load, offering a few weeks breathing space to both GP and patient for things to ‘sort themselves out’ 2-84, easing a long term burden, and self-preservation, though the words ‘off-loading’ and ‘dumping’ were mentioned in a couple of interviews”. Potentially most significantly, several of the GP participants expressed a concern that their patients might feel rejected by them in being referred to counselling (as Foucault might put it that the patient’s subjectivity had been threatened by rejection by ‘the gaze’) – as one of them summarized: “So I do find myself hoping they’re not going to be offended when I’m going to send them. I try not to let them feel rejected and I go a bit over the top about how brilliant they [counsellors] are 22-101”. This interestingly raises the notion that GPs may be concerned that their relationship with their patient may be *damaged* by a referral to a counsellor; in fact their research concluded that “On-going GP patient relationships were mostly not thought to be endangered in any way by these referrals, and might even be strengthened”. Perhaps as Balint (1964:231) suggested, however “Reassurance is much too often administered for the benefit of the doctor, who cannot bear the burden of either not knowing enough or of being unable to help”.

Having now understood something of the literature relating to the clinical medical model in medicine and how this might impact the doctor/patient relationship and subsequently a counsellor/client relationship, the next section considers the literature which specifically relates to the medical model in terms of understanding human distress. We have seen that the medical model in physical medicine has potentially direct repercussions for counselling and so it is possible that it has an equal if not greater impact in terms of how it has developed in explaining human distress (i.e. for issues of ‘mental health’ or psychopathology). Within this review of literature the researcher has also endeavoured to highlight what has been written about the development of the role of the doctor in dealing with human distress (as GP,

psychiatrist and eventually therapist/analyst) as it is probable that these subjects play a significant role in influencing therapists working in any setting.

2.2.3 Literature concerning discourses of the medical model in conceptions of human distress

How do GPs and psychiatrists view issues of mental health? Where have those ideas come from and how might they influence both how doctors relate to their own patients and how they might view the involvement of a therapist in the 'treatment' of that patient? There are a number of writers who have given their attention to discussing the different conceptions of human distress in terms of both their theoretical bases and how society has organised itself in response in terms of institutions and practices (most notably Abma, 2004; Bentall, 2004, 2011; Foucault, 1967, 1973; Parker et al (1995); Siegler and Osmond (1974) and Shorter, 1997). In terms of theory, this field is also known as psychopathology - as Maddux et al (2008:3) clarify "conceptions of psychopathology do not try to *explain* the psychological phenomena that are considered pathological but instead tells us which psychological phenomena are considered pathological and thus need to be explained." The very term psychopathology can be argued to stem from the medical model and so as "we live in a culture linguistically dominated by medical models" (Boyle, 2006:193) the researcher has chosen, in the spirit of Foucault, to use the term 'conceptions of human distress' as representing terminology from a less dominant discourse and as an attempt to keep in view that the medical model is one of several competing discourses.

This section therefore considers the literature relating to medical model conceptions of human distress in terms of a brief overview of their history (as required by the chosen methodology in order to give a sense of how particular discourses have emerged) including how the relationship between doctor and patient has developed

and been used, and a consideration of the core philosophical assumptions of such conceptions, because as Maddux et al (2008:11) put it, “we have to stop struggling to develop a scientific conception of psychopathology and attempt instead to try to understand the struggle itself – why it occurs and what it means”. This is relevant to this study because the researcher will be asking participants about how they experience the medical model in their work and it may be important to locate those experiences in terms of the assumptions that they, or those they interact with, are making about how they see their clients/patients.

According to Siegler and Osmond (1974) and as summarized by Kihlstrom (2002:281) “the history of psychology can be traced in terms of three major models of psychopathology. The ***supernatural*** *model* [which] prevailed before the eighteenth century Enlightenment …the ***moral*** model which prevailed in the late eighteenth and early nineteenth centuries …[and the] ***medical*** model which began to emerge in the nineteenth century”.

The first of these “assumes that psychology reflects the possession of the individual by demons; by implication, the proper response to psychopathology is exorcism.” (Kihlstrom, 2002:281). Rather than seeing conceptions of human distress as “social constructions that inevitably reflect the wider social ideologies of the day” (Joseph, 2007:429) Shorter appears to re-interpret the past from a modernist, medical model standpoint; “human society has always known psychiatric illness, and has always had ways of coping with it” (Shorter, 1997:1). He details a richer picture of a less homogenous approach to human distress prior to the eighteenth century and highlights the differences in arrangements between urban and rural areas: “the urban world has always had to confront the problem of the homeless psychotic or demented individuals and cities have organised institutions to accommodate them”, (Shorter, 1997:4) whereas rurally families were generally required to look after their

disturbed relatives. Foucault (1967:59) also notes that “Confinement was an institutional creation peculiar to the seventeenth century [and]…in the history of unreason it marked a decisive event: the moment when madness was perceived on the social horizon of poverty, of incapacity for work, of inability to integrate with the group; the moment when madness began to rank among the problems of the city”.

Foucault focused on the concept of unreason as “For classical man, madness was not the natural condition, the human and psychological root of unreason; it was only unreason’s empirical form; and the madman…disclosed that underlying realm of unreason which threatens man and envelops…all the forms of his natural existence” (Foucault, 1967:78). For Foucault, unreason, prior to the eighteenth century formed a distinct conception of human distress.

Siegler & Osmond’s (1974) moral model of the mid to late eighteenth century “assumes that psychopathology - or, more precisely, abnormal behavior- is deliberately adopted by the individual, much in the manner of criminal behavior; by implication, the proper response…is confinement and other forms of punishment.”(Kihlstrom, 2002:281). From the literature it appears that doctors became involved in asylum regimes around the end of the eighteenth century – Foucault (1967:238) notes that “until the end of the eighteenth century, the world of madmen was peopled only by the abstract, faceless power which kept them confined; within these limits it was empty, empty of all that was not madness itself…”

It is around this time, the end of the eighteenth century, that the literature indicates the emergence of the first use of an early type of psychotherapy. Shorter (1997:8) comments that “it was not the notion that madness was curable that changed at the end of the eighteenth century… rather it was the notion that institutions themselves could be made curative…” Asylums were re-organised at this point and according to Shorter (1997:18) “The founders envisioned two aspects of life in an asylum as

therapeutic – the setting itself with its orderly routines and communal spirit, and *the doctor-patient relationship*. A particular form of this relationship was often called "moral therapy"" (emphasis added). He goes on to argue that "Physicians began using techniques related neither to the giving of medication nor to physical procedures. This was the advent of psychotherapy; the formal use of the doctor-patient relationship to restore patients" (Shorter, 1997:19), perhaps giving psychotherapy a unique definition and with it, an existence permanently framed by the medical model.

Supporting this view Abma (2004:96) also states that "Moral treatment consisted of a deliberate system of persuasion and influence, centered around the moral authority of the doctor". It is important to note the emphasis here on the *moral* authority of the doctor – as Foucault (1967:257) also highlights, "the doctors intervention is not made by virtue of a medical skill or power that he possesses in himself and that would be justified by a body of objective knowledge. It is not as a scientist that *homo medicus* has authority in the asylum, but as a wise man". This seems to be drawing upon the notion of Paterson's (1957) Aesculapian authority as previously discussed, and this will be returned to in the next section when considering how elements of medical model thinking have been applied to psychotherapy.

According to Foucault (1967), Samuel Tuke was a key figure in the development of the asylums and it was under his auspices that the role and symbolic structure of the family assumed a great importance (which can be argued is still seen today) – "In the great reorganisation of relations between madness and reason, the family, at the end of the eighteenth century, played a decisive part – simultaneously imaginary landscape and real social structure…The entire existence of madness…was enveloped in what we may call, in anticipation, a "parental complex"" (Foucault, 1967:240). This was reinforced in his view by the fact that asylum inmates were

regarded legally as minors. He goes on to highlight that in the asylum setting, “Tuke, precisely reconstitutes around madness a simulated family which is an institutional parody but a real psychological situation. Where the family is inadequate, he substitutes for it a fictitious family décor of signs and attitudes” Foucault (1967:239). The role of the doctor, “…the medical personage…had to act not as the result of an objective definition of the disease or a specific classifying diagnosis, but by relying upon that prestige which envelops the secrets of the Family, of Authority, of Punishment, and of Love” (Foucault, 1967:259). He later argues that Freud “exploited the structure that enveloped the medical personage” (Foucault, 1967:263), where “the madman remains a minor, and for a long time reason will retain for him the aspect of the Father” (Foucault, 1967:241). In this analysis Foucault highlights the purposeful introduction of the symbolic structure of the family as a therapeutic frame into the asylum system which was then inherited by psychoanalysis and arguably psychotherapy more broadly.

According to Abma (2004), Siegler & Osmond (1974), Parker et al (1995) and Foucault (1969) in the nineteenth century “medicine (as an institution possessing its own rules, as a group of individuals constituting the medical profession, as a body of knowledge and practice, as an authority recognised by public opinion, the law and government), became the major authority in society that delimited, designated, named and established madness as an object” (Foucault, 1969:46). As Parker et al (1995:13) summarise, “the case of the mad as pitiable mentally ill persons needing care and rehabilitation began as the Modern Age, or modernity – the representation of the world as organised by meta-narratives of humanized science, progress and individual meaning – came into being”.

For Foucault (1967:188), it was “When…this great experience of unreason…was dissociated, when madness…was nothing more than disease…it is precisely here

that psychology was born – not as the truth of madness, but as a sign that madness was now detached from its truth which was unreason…".

Staying with the literature which details the history of the development of the medical model's use in the field of human distress, under a broad title of the 'first biological psychiatry' Shorter (1997:28) summarises theories that favoured a biological explanation for human distress, from Reil's notion of "irritable nerve fibers" in the brain to phrenology and beyond and is untroubled by their eventual abandonment – "no matter. What is important is that these early psychiatrists had some gut sense of organicity in the afflictions of their patients". He also hails the prescience of these early pioneers in anticipating the role of heredity in understanding mental illness.

Those writers who focused on the social and environmental context of human distress were retrospectively grouped under the label of "romantic psychiatry" according to Shorter (1997:29) & he characterises a tension between the Enlightenment focus on reason and the Romantic Movement's focus in the late eighteenth and early nineteenth century on feeling and sentiment. "Their underlying premise was that social circumstances…not biology, governed passion, and that strict adherence to moral precepts was required for the control of these passions" (Shorter, 1997:30). This marks a fundamental distinction in psychiatry to which we shall return when considering literature regarding the underlying philosophy of such models – a distinction which remains contested to the present day and as such may be experienced by therapists working in any setting.

From the period 1880-1920 all the writers detail the growth in sanatoria across Europe in response to the need to treat what became known as "nervous disorders" (Abma, 2004:100) "such as anxiety, neurotic depression, and obsessive-compulsive behaviour" (Shorter, 1997:22) which largely "did not belong to psychiatry. They were assigned to family medicine or to one of the organic specialities such as neurology

(Shorter, 1997:22). Abma (2004:102) argues that psychiatrists sought to "bridge this divide…To this end they introduced [the] concept… of prevention. Assuming that untreated neurosis would degenerate into psychosis, psychiatrists reasoned that moral treatment had failed because insanity reached a chronic state before psychiatrists saw it. Hence in the name of prevention they claimed jurisdiction over the diagnosis and treatment of neurosis". At this point it is interesting to note that, according to Abma (2004:101), "both neurologists and "mental healers" […] implicitly counted on the same principle employed by asylum doctors in moral treatment, that is, the beneficial psychological influence of the authority of the physician".

Abma (2004:105) summarises that this formed the backdrop to Freud's work – educated as a neurologist he became convinced that "that these neurotic symptoms had mental causes. This was the starting point for a whole new way of theorizing about mental illnesses; they stemmed from repressed thoughts, memories and impulses, hidden in the unconscious". Abma also makes the same point as Foucault in highlighting how Freud inherited the asylum tradition; "By acting as a substitute parent, the doctor would induce the process of "transference", by which the patient subjected himself emotionally to the psychoanalyst, a procedure which was reminiscent of the way asylum and sanatorium doctors tried to exert moral authority over their patients" (Abma, 2004:105). As we have seen earlier in this chapter there are writers such as Stein (1985) who explore how far such processes are still in evidence today between both doctors and therapists and their patients/clients.

Shorter (1997:145) characterises psychoanalysis as simply creating a "hiatus" in the glorious history of biological psychiatry which was "interrupted by half a century of divorcing brain from mind with the dominance of Freud's theories" (Shorter, 1997:viii) with his overall view being that "If there is one central intellectual reality at the end of the twentieth century, it is that the biological approach to psychiatry – treating mental

illness as a genetically influenced disorder of brain chemistry – has been a smashing success" (Shorter, 1997:vii). This is a view which plenty of writers have disputed including Breggin (1993) in his critique of psychiatry in the USA and perhaps most notably Bentall (2010:1) who said that "Far from being a success, there is compelling evidence that the biological approach has been a lamentable failure". For Shorter, it was "Kraepelin, not Freud, who is the central figure in the history of psychiatry" (1997:100) and whose work created the basis for the shift from seeing psychiatric "illness vertically rather than cross-sectionally: trying to understand the patient's problems of a given moment in the context of his or her lifetime history, in contrast to the biological approach" (1997:99). Freud's work is dismissed by Shorter (1997:100) as being "based on intuitive leaps of fantasy [which] did not stand the test of time". As Siegler (2005:160) has noted "many critics pin both Freud and psychoanalysis to one, usually very early, position and then mistakenly think that they have captured the essence of the discipline" and perhaps this is the case here - the view from psychoanalysis is discussed in more depth in the next section which considers literature on the medical model specifically in psychotherapy.

The reference to what might be loosely termed a genealogical approach is similar to what is being attempted here - as Hook summarises (2001:37) "Foucault's conceptualization of discourse indispensably requires the role of historical contextualization; discourse analysis only finds its real usefulness within the agenda of a 'history of systems of thought' (Foucault, 1977)". This section of the review of the literature is therefore attempting to detail such a history of the development of the medical model in human distress in order to provide the backdrop to present day discourses which counsellors and psychotherapists may experience in their work (whether in a modern day 'clinic' such as a GP surgery or in private practice). As Illich (1976:172) puts it "All disease is a socially created reality. Its meaning and the response it has evoked have a history. The study of this history will make us

understand the degree to which we are prisoners of the medical ideology in which we were brought up".

In terms of the next phase of historical development, therefore, Abma (2004) frames the twentieth century in terms of three main conceptions of human distress coinciding with particular, if overlapping, periods in history. The first of these was the mental hygiene movement (1914-1940) "After the First World War…problems of adjustment, deviance and illness were increasingly subsumed under the banner of mental hygiene… it signified optimism within psychiatry that all forms of disorder…could be cured or managed by scientifically supported therapeutic interventions" (Abma, 2004:110) – he also suggests that psychoanalysis and behaviourism were in competition with each other during the 1920's and 30's, whose "tenets, implying a certain plasticity of human nature, created the possibility of non-residential treatment, which in turn enhance therapeutic optimism. As a result of all this, psychiatric medicine was freed of its dependence on disease and fired with a new ambition to intervene in the lives of the healthy" (Abma, 2004:110). No longer dependent on the notion of physical disease, perhaps at this time as Illich (1976: 172-3) suggests human distress', "status as a 'sickness' depends entirely on psychiatric judgement". Abma suggests that it was around this time that a new framework emerged, "that of a continuum ranging from the normal to the pathological" (Abma, 2004:110), rather than distress being categorised in the more black and white fashion of disease or health. At one end of this continuum lies the increasing prevalence of the use during the 1930's of psychosurgery (e.g. prefrontal lobotomy) which seems to be quite clearly about biology and it is clear that in reality there is a melting pot of ideas in currency at this time.

The second key phase of the twentieth century saw the dominant theory of distress move away from biology. This period termed "Adjustment (c1930-1960)" by Abma

(2004:111), saw the field needing to account for the experiences of otherwise healthy soldiers and officers who fell prey to a range of symptoms arising from their roles in the Second World War. Such experiences came to be seen as “a normal response to an abnormal environment” and that such interpretations “pushed the general orientation of clinical professionals in decidedly social directions” (Abma, 2004:111).

Following the war, it is contended that the general population in Western cultures “sought therapeutic assistance more insistently than ever before, and by 1960 mental illness had become a subject of great interest to the general public…as a result, the idea of “psychotherapy for the normal” became widely accepted” (Abma, 2004:113). The non-medical model method of counselling developed by Rogers in the 1940’s fitted well with this new demand – “Rogers’ method brought about a decisive shift of emphasis, from an exclusive concern with the pathological to a focus on ordinary unhappiness and alienation” (Abma, 2004:114) – his approach also heralded “a more democratic relationship between professional and client” (Abma, 2004:122).

This period also saw the rise of behaviourism which Abma (2004:114) summarises as “presupposing that all behaviour was learned through reinforced stimulus-response associations, behaviourists claimed that this included behaviour associated with mental illness, and that it could also be unlearned, given the appropriate methods.” He argues that Eysenck and his team explicitly set out to oppose “psychoanalysis with all the methods at their disposal. Apart from claiming a greater effectiveness for behaviour therapy, the bottom line for Eysenck was always the scientific superiority of behaviourism”. Whilst he argues that the increasing prevalence of both person-centred counselling and behaviour therapies “eventually contribute[d] to the decline of psychoanalysis in its classic form. Nevertheless, the proponents of these new therapies agreed with the psychoanalytic view that mental

problems have psychological causes rather than biological ones… (Abma, 2004:117).

The third twentieth century period elucidated by Abma (2004, 117-8) is termed "Radicalism (c1960-1980), in which "Alternative interpretations of mental illness, such as anti-psychiatry, joined forces with the anti-establishment battle of the counterculture…". He explains the important contributions of Szasz (1960) in the US and Laing in the UK both of whom argue that the origins of human distress do not lie in chemistry or biology but argue instead that "mental illness is a myth, whose function it is to disguise and thus render more palatable the bitter pill of moral conflicts in human relations" (Szasz, 1960:118) and that "just as Kierekgaard remarked that one will never find consciousness by looking down a microscope at brain cells…so one will never find persons by studying persons as though they were only objects" (Laing, 1967:20). As Illich (1976:172) summarises, writers such as "Liefer, Goffman, Szasz and Laing, and others are all interested in the political genesis of mental illness and its use for political purposes."

During this period, in 1964, frustrated by her experience of working in a mental health center in America, Siegler and her colleague Osmond set out to try to identify the variety of conceptions of human distress currently in operation amongst the disparate group of professionals with whom they were working. After identifying eight distinct 'models of madness' they concluded that "what we have in psychiatry is worse [than the Tower of Babel]: each person uses a hodgepodge of bits and pieces of ideas, theories, notions and ideologies in order to engage in a supposedly common enterprise with others similarly confused" (Siegler & Osmond, 1974:11). They describe each of these models in terms of a number of distinct characteristics such as how each one approached defining what the issue is for the client/patient, any notion of aetiology, approaches to treatment etc. Of the eight models they identified

only three involved any form of psychotherapy (the psychoanalytic, psychedelic and family interaction models). Significantly they recognised, however, that “Our classification system implies that all the models are equal, but in fact there is one model which is more equal than the others; this is the medical model” (Siegler & Osmond, 1974:19).

Shorter’s (1997) exhaustive history of psychiatry fully describes developments in psychopharmacology in the twentieth century and he concludes, fully endorsing a biomedical model of distress that “In two hundred years’ time, psychiatrists had progressed from being the healers of the therapeutic asylum to serving as gatekeepers for Prozac. Psychiatric illness had passed from a feared sign of bad blood – a genetic curse – to an easily treatable condition not essentially different from any other medical problem…” (Shorter, 1997:325). He appears, however, to be contradictory in his statements about the role of the doctor-patient relationship – on the one hand he (1997:314) says “There is no doubt that psychotherapy helped patients feel more comfortable with their psychiatrists…yet lifting symptoms rather than cultivating a sympathetic rapport in the office remained the ultimate therapeutic objective” but then goes on to claim a more significant role for therapy: “…patients began to view physicians as mere conduits to fabled new products rather than as counsellors capable of using the doctor-patient relationship itself therapeutically”. He is of the firm belief, however, that it is the specific nature of the role of *physician* which carries the therapeutic impact – “…the history of medicine suggests that patients derive some kind of bonus from the knowledge that they are dealing with a physician” (Shorter, 1997:327). Shorter’s version of psychotherapy, however, appears to consist only of the reliance on this Aesculapian authority. Quoting an observer he states ““Human suffering responds to the spoken word rendered by compassionate persons cast in the role of healer” (Shorter, 1997:327).

The researcher has now considered the literature regarding the historical development of the medical model conception of human distress in order to help locate current discourses which may emerge in the empirical research. One of the key features of this history has been the waxing and waning of the popularity of biological explanations of human distress and in general, a real lack of consistency amongst the various writers considered as to exactly what justifies the label of medical model – is it just the involvement of a doctor or also the assumption of organicism? The way terms like disorder, illness and mental defect are used almost interchangeably makes it very difficult to discern such distinctions. As it will be important for the researcher to understand when the medical model is being spoken of they will now briefly review the literature which may help elucidate this question.

According to Engel (1977:318-9), who considers the biomedical models' underlying epistemological and ontological assumptions as they relate to psychopathology; "The dominant model of disease today is biomedical, with molecular biology its basic scientific discipline...It …not only requires that disease be dealt with as an entity independent of social behaviour, it also demands that behavioural aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes. Thus the biomedical model embraces both reductionism, the philosophic view that complex phenomena are ultimately derived from a single primary principle, and mind-body dualism, the doctrine that separates the mental from the somatic". He therefore called for a new biomedical model, suggesting the need for a bio-psychosocial model, arguing that "…while the medical model constitutes a sound framework within which to understand and treat disease, it is not relevant to the behavioral and psychological problems classically deemed the domain of psychiatry" (Engel, 1977:318). He discusses that such an approach would benefit all branches of medicine (perhaps in their clinical aspects), not just psychiatry and suggests that the biomedical model has become a dogma: "Biomedical dogma requires that all

disease, including “mental" disease, be conceptualized in terms of derangement of underlying physical mechanisms” (Engel, 1977:320).

So whilst Engel sees the medical model as *somatogenic* (meaning “originating or developing from the body” [Chambers, 2010]), Kihlstrom (2002:280-1) suggests that the “common association of the medical model with somatogenic theories and biological treatments reflects a deep misunderstanding” and that “the ***medical*** model assumes only that psychopathology is the product of natural causes that can be identified by the techniques of empirical science” [original emphasis]. He goes on to describe a *psychogenic* explanation for psychopathology (meaning “originating in the mind” [Chambers, 2010]) which he links to cognitive and behaviour therapy. Using such an explanation, he suggests that ‘natural causes’ are implied to result in “underlying mental abnormalities - disorders of cognitive, emotional, and motivational function that underlie the abnormalities of experience, thought, and action that present themselves as palpable signs and symptoms of mental illness” (Kihlstrom, 2002:293). Without any account of *how* such abnormalities result from ‘natural’ psychogenic causes (as opposed to either biological or presumably man-made, cultural or environmental causes) this argument appears to remain incomplete.

Underlying Kihlstrom’s argument is an assumption that somatogenic and psychogenic models refer to something qualitatively *different* in terms of what causes human distress – i.e. there is an inherent assumption of Cartesian dualism (introduced in chapter one) or as Reznak (1991:73) puts it “the *Dualist Fallacy* – the fallacy of assuming that the mind is not identical to any physical thing (the brain included)”. Fratteroli (2001:18) disagrees that Cartesian dualism is a fallacy or error – “based on my experience of the psychotherapeutic process, I am convinced that the mind-body problem is inherent in human nature. We may experience it either as an inner moral conflict or as self-alienation, but both elements are always present to

some degree". He argues that the doctrine of scientific materialism that Reznak espouses "makes it all too easy to persuade ourselves that there is no mind-body problem, no inner conflict or self-alienation, and therefore no need to examine the inner life of the soul in psychotherapy (Fratteroli, 2001:20). He contends instead that whilst brain processes are a "necessary condition" for human experience or soul this is similar to the way that soil is a necessary condition for a tree – they are not "sufficient cause" (Fratteroli, 2001:8). Bentall (2011:169) goes further to challenge "the false dichotomy between biological and psychological approaches, pointing out, for example, that adverse early life experiences can lead to profound changes in brain structure and functioning".

Whilst Parker et al (2005:15) argue that "The keystone of the medical model and of psychiatric practice is that there is an organic foundation to the distress people sometimes experience", they go on to suggest that "…we need have no trouble accepting that biological processes inform the sense we make of the world if we hold firm to the idea that human beings *attribute* meanings to those biological changes and if we always attend to patterns of power that structure what we are allowed to attribute to what." For those involved with working with those in distress the critical question still remains, however, as to how far biological processes (whether from mind or body) underlie their experience - should we be pursuing biochemical causes and treatments *as well as* seeking to highlight the social construction of meaning? (as introduced in chapter one). It will be important for the researcher to potentially locate where participants sit in terms of this fundamental question in order to understand which discourses are being invoked.

So, it would appear from the literature that medical model conceptions of human distress not only include that which might be described as biological psychiatry i.e. "treating mental illness as a genetically influenced disorder of brain chemistry"

(Shorter, 1997:vii) but also the stripped down version elaborated by Kihlstrom (2002:281) which he argues is "centered on particular rules regulating two primary social roles: the doctor and the patient". He suggests that it is the notion of "Aesculapian authority" (as described by Siegler & Osmond (1974) already referenced in section 2.2.2), which forms the basis of the medical model of human distress. There are five key components to the doctors' role in this – through the use of his authority; (i) to investigate the disorder presented, (ii) to make a diagnosis (iii) to inform the patient of their findings, (iv) to absolve the patient from blame and finally (v) to "create the conditions for the afflicted person to return to health and his or her proper role in society" (Kihlstrom, 2002:282).

Having now considered the literature regarding the medical model in medicine, how medical models of human distress have developed and how both of these have influenced the evolution of the doctor/patient relationship, the researcher will now turn to a review of the literature which details how the medical model has been applied in psychotherapy.

2.2.4 Literature re the discourse of the medical model in psychotherapy

Interestingly the researcher has been unable to find any research studies which have explored how therapists perceive their work in relation to any definition of a medical model. This section will therefore consider the theoretical literature as it relates to different conceptions of the medical model in psychotherapy and the primary alternatives suggested at what Sparks, Duncan and Miller (2008:454) have termed a "metatheoretical", non-modality specific level (those arguably offering an alternative meta-narrative to that of medicine). This will help the researcher understand how participants may bring a medical model influence to bear internally on their practice in addition to how they experience it externally. Some modality specific examples will be used to illustrate how these difference conceptions of the medical model are used

in practice, (but space precludes this being an exhaustive review of literature per modality).

The first point of interest noted by several writers (Boyle, 2006; Elkins, 2009; Wampold et al, 2001) is that the medical model, as the dominant cultural discourse, is very hard to not only confront but to even see in the first place – ""…for more than a century we have become so accustomed to describing psychotherapy in medical model terms that it is difficult, if not impossible, to remove the medical model "grid" to see the process of psychotherapy as it actually is" (Elkins, 2009:71). Boyle (2006:191) also notes "the extraordinary psychological and social power of medical models, and therefore the great difficulty of persuading people to listen to, understand, and accept alternatives". Boyle goes on to suggest that one of the reasons that the medical models have such power is that "they borrow credibility from the prestigious languages of science and medicine and receive strong support from the pharmaceutical industry" (Boyle 2006:199). It is clear that some writers are loathe to relinquish such power - in discussing what he sees as an alternative model, Wampold (2001:2) is at pains to not only retain claims to scientific credibility but to use science to disprove the medical model – "the scientific evidence shows that psychotherapy is incompatible with the medical model and that conceptualizing psychotherapy in this way distorts the nature of the endeavour". As noted earlier in this chapter, the researcher wonders how far it is possible to truly divorce science from the medical model given the embedded nature of the observers 'gaze' in science.

In the relevant literature there are several writers who have suggested that the medical model in psychotherapy is essentially intended to be understood metaphorically rather than literally (Ahn and Wampold 2001; Bettelheim, 1982; Elkins, 2009, Hyman, 1999; McCready, 1986; Wampold, 2001). In understanding any

discourse Foucault (1969:64) notes the importance of considering two distinct fields – a "*field of presence* (…all statements formulated elsewhere and taken up in a discourse…) [and]…a *field of concomitance* (this includes statements that concern quite different domains of objects…and belong to quite different types of discourse, but which are active among the statements studied here, either because they serve as analogical confirmations or…because they serve as models that can be transferred to other contents…)" The medical model in Foucault's terms belongs to the field of concomitance as "essentially the medical model of psychotherapy is an analogue to the medical model in medicine, rather than a literal adoption. The medical model in medicine contains the same components as the medical model of psychotherapy except that the theories, explanations, and characteristic techniques are physiochemically based" (Wampold, 2001:14). Put this way Wampold appears to be making the same distinction between somatogenic and psychogenic causes as Kihlstrom (2002).

Bohart and Tallman (1999:5) continue that "in the medical model, the therapist is analogous to a physician" and describes the key features of the model as being diagnosis, and the recommendation and application of a treatment intervention that "cause change in the client, thereby alleviating the symptom". Bettelheim (1982:39-40) argues that the roots of the use of the term 'mental illness' can be traced back to Freud but that he never intended it to be taken literally: "If this metaphor is not recognized as such, but, rather, taken as referring to objective facts, we forfeit a real understanding of the unconscious and its workings. In this metaphor, the body stands for the soul. If the metaphor is translated literally… our psyche, or soul – for Freud the terms were interchangeable – seems to become something tangible. It acquires something akin to a physical existence, like a bodily organ; hence its treatment becomes part of medical science." Reznak (1991:73), however, suggests that the practice of talking about mental problems as mental illness in fact reaches back even

further - “since Hippocrates mental problems like depression have been seen as illnesses”.

Whilst McCready (1986) suggests that using the phrase ‘medical metaphor’ would be more helpful than medical ‘model’ in order to keep its proper status in mind, a number of practitioners have written about their disagreement with the use of this model altogether, including Elkins (2009:67), who contends that the superimposition of this model uses “medical terms to describe what is essentially an interpersonal process that has almost nothing to do with medicine”.

Wampold (2001:13-14) deconstructs the medical model as used in psychotherapy, identifying five key components as follows: (i) there is a client who is “conceptualized to have a disorder, problem or complaint” – whilst some therapeutic schools may choose to use diagnosis, (such as some schools of psychoanalysis according to Hyman (1999): “In health care, the diagnosis determines the treatment; in psychoanalysis the "treatment" is "diagnosing" and vice versa”) Wampold argues that this is not essential to the model in psychotherapy, (ii) That “a psychological explanation for the client’s disorder, problem or complaint is proposed”, (iii) that “each psychotherapeutic approach posit a mechanism of change”, (iv) that such approaches, “to varying degrees…prescribe specific therapeutic actions” and finally (v) “the therapist provides treatment that contains specific therapeutic ingredients that are characteristic of the theoretical orientation as well as the explanation of the disorder, problem or complaint…The specific ingredients are assumed to be responsible (i.e. necessary) for client change or progress towards therapeutic goals”. This is characterised as the specific ingredients model. It should perhaps be noted however, that according to Hyman (1999), “The outcome of analysis is…an entirely subjective matter and quite different from that which is expected in a medical model”.

It is also worth noting that this deconstruction does not fully take into account the power involved in the position of the doctor / therapist.

Wampold et al (2001:268) argue that a key feature of the medical model is that primacy is given to the "specific ingredients" of psychotherapy-as-treatment rather than "common or contextual factors" both of which have formed the basis of alternative meta-theories of why psychotherapy works. An example of psychotherapy-as-treatment might be seen in the description that Siegal (2005:159) offers of some psychodynamic analytic reasoning which uses "interventions tailored to the patient and tested in the "laboratory" of the sessions". The term 'common factors' was first used by Rosenzweig (1936:412) when he wondered "(1) whether the factors *alleged to be* operating in a given therapy are identical with the factors *that actually are* operating and (2) whether the factors that actually are operating in several different therapies may not have much more in common than have the factors alleged to be operating".

Essentially the common factors model asserts that regardless of the theory of the *cause* of human distress, it can be ameliorated by any therapy which utilises some identified so-called common factors. Summarised by Sparks, Duncan & Miller (2008:457), Frank (1961) gave these as : "(1) an emotionally charged, confiding relationship with a helping person; (2) a healing setting; (3) a rationale, conceptual scheme or myth that plausibly explains the patients symptoms and prescribes a ritual or procedure for resolving them and (4) a ritual or procedure that requires the active participation of both patient and therapist and that is believed by both to be the means of restoring the patients' health".

Sparks et al (2008:454) usefully trace the "evolution of the common factors as a metatheoretical framework for research and the emergence of a transformative clinical practice" from its inception in Rosenzweig's 1936 paper through to

developments in the twenty-first century, including Lambert's (1986) summary of outcome studies which identifies a "percentage variance attributable to four common factors" (Sparks et al 2008:458) which seems to imply that the factors act independently of each other. Wampold (2001:26) however suggests that it is the underpinning context in which the therapy takes place which is of overriding importance; "the healing context and the meaning attributed to it by the participants (therapist and client) are critical contextual phenomena". He suggests therefore that "in a contextual conceptualisation of common factors, specific therapeutic actions, which may be common across therapies, cannot be isolated and studied independently" (Wampold, 2001:26). In a subsequent paper Wampold et al (2001:269) state that "the alternative to the medical model is not a collection of common independent factors, such as the working alliance, expectation of progress, and therapist empathy. Every therapy should have a rationale, be administered in a healing context, and contain therapeutic actions consistent with the treatment rationale." The researcher, however, wonders how 'alternative' this model is to the medical model with its use of words like 'treatment'? Ironically, Wampold et al (2001:270) comment that "One cannot examine the evidence, find the medical model scientifically unsupported, and continue to use medical model language."

This perhaps serves as an example of how difficult it is to recognise and move past a medical model discourse – in the literature writers such as Boyle, (2006:191) note that "such is the ideological power of medical models that thinking outside them is as much a challenge for those who develop alternatives as for those with whom they are trying to communicate". Boyle (2006:192) goes on to suggest that real alternatives to medical models would need to have two essential features – first that "they would remove biology and genetics from their current privileged position and emphasize the importance of interpersonal and social factors in causing emotional distress and disturbing behaviour", and second that "they would have to present a

reconceptualization of what is usually called mental disorder and do this in a way that could not easily be absorbed into a medical framework". He stresses the importance of a refocusing on the *meaning* that experiences have to the client in terms of their life and social context and that ultimately, "the task for alternatives to medical models is to put the rationality back into madness" (Boyle, 2006:199).

This follows arguments by several authors including Bolton (2001:188) who noted not only that "in the attribution of madness it is apparently failure of intelligibility that is crucial", but that Foucault discussed the medical model as inherently including the "idea of madness as lack of reason, stripping it of all possible significance except as mere disorder". Parker et al (2005:12) wonder "what if the very act of dividing reason from unreason were a product of culture?" and indeed Bolton (2001:188) notes that "the common thrust of the anti-psychiatry critiques was that the medical model failed to see what meaning there was in apparent disorder". Frattaroli (20001:62) argues that …the whole Medical Model approach to psychiatry …is afflicted by this same fearful need to hide from the existential moment of self-awareness".

An additional factor which emerges from a review of the literature in understanding the dominance of the medical model in our current culture is that it accrues both status and money to its proponents. Kihlstrom (2002:297) acknowledges that there is a desire that "By placing diagnostic concepts and practices on a firmer scientific base, a shift from symptoms to laboratory tests will also reinforce the status and autonomy of clinical psychology, as well as the profession's claim to third-party payments for services". Simon & Wynne (2006:187) note that "The biogenetic model of mental disorders that now dominates the mental health field is largely a fiction created by psychiatry and supported by the massive pharmaceutical companies whose main goal is the sale of psychiatric drugs" and wonder whether it is possible to "explicate the reasons why we hold on to this false medical terminology beyond the

very real possibility that we earn our livings in a field that has embraced the medical model and is largely funded by medical insurance and other third-party payers?" (Simon & Wynne, 2006:188). Elkins (2009) makes the argument that eschewing the medical metaphor would lead to a loss of power and prestige for the profession, which is partly why it is so attractive - "the medical model has remained the dominant descriptive system for psychotherapy, not because it offers the most accurate description of what actually occurs in therapy but, rather, because the model's association with medicine and science gives psychotherapy a level of cultural respectability and economic advantages that other descriptive systems do not." (Elkins, 2009:73)

So what does the literature tell us might be a meta-theoretical alternative to the medical model metaphor in psychotherapy? Stiles and Shapiro (1989:522) have suggested that in research terms there is "an investigative paradigm that we will call the drug metaphor. Rooted in the broader medical model of psychological disorder and its treatment, this paradigm views psychotherapy as comprising active ingredients, supplied by the therapist to the client, along with a variety of fillers and scene-setting features". As summarised by Guy, Loewenthal, Thomas and Stephenson (2012) an alternative is the idea of therapy as *dialogue* - Bohart & House (2008:195-6) suggest that "In contrast to the idea that the therapist is 'treating' a 'disorder', therapy becomes a co-created dialogue between two (or more) intelligent, living, embodied beings. The guiding metaphor for this approach is therefore *conversation* and *dialogue*", which occurs within an interpersonal therapeutic relationship. "Psychotherapy is conceived of, above all, as *a practice*" (see also Heaton, 2010). Siegel (2005:152) considers how psychoanalysis has developed in this regard and suggests that "Relational psychoanalysis maintains that meaning is not discovered in the patient, but created in a field of potential space between analyst

and patient. Each participant in the dialogue co-creates the analysis." This view seems to sit within the therapy-as-dialogue model proposed above.

This section has considered the literature regarding the alternative meta-theories to the medical model in psychotherapy in terms of; the medical model as *metaphor*, the common factors model, the contextual model and therapy-as-dialogue. Broadly speaking regardless of the terminology actually used all these models assume that therapy is *not* a medical-like treatment or intervention but a practice that should be understood primarily in terms of *relationship*. In addition to those writers already mentioned, there is support for this view amongst those who have explored the social causes of mental distress more generally beyond a consideration of the role of psychotherapy - (Bentall 2004; Horwitz 2002; Mirowsky and Ross, 2003; Pilgrim et al, 2009) - who summarise the strong interdisciplinary case for the importance of personal relationships in both the creation and amelioration of mental health problems. In line with the call for the widespread adoption of a biopsychosocial model for understanding such experiences (Engel, 1977), they do not suggest that biology does not play a part, but that that part is a subordinate one.

Having now considered the literature as it relates to the discourse of the medical model in medicine and how it has impacted the development of the GP/patient relationship, discourses of the medical model in understanding human distress and medical model discourses within psychotherapy itself, in the final section in this chapter the researcher will now summarise literature which offers critiques of such ideas. As the very genesis of this study has been framed in terms of a potential conflict between a modernist, scientific world and a postmodern one interested more in the nature of subjectivity and language these critiques have been grouped in terms of how they might be located within modern and postmodern epistemologies. As mentioned previously, literature on these critiques has been included in order to

contextualise the participants' own possible interpretations of their experiences of the medical model in their work and the researcher's analysis of them.

2.2.5 Literature re postmodern critiques of the medical model

2.2.5.1 Questioning meta-narratives

As mentioned, the philosophy underlying this entire debate might be characterised as being rooted in the respective epistemologies associated with modernism and postmodernism which, according to Osborne (1992), are not *chronological* categories, but *qualitative* ones. As briefly outlined in chapter one and exemplified in the literature on the biomedical model above, modernism is characterised as the post-Enlightenment triumph of reason over superstition and ignorance, order over chaos and the championing of science as a method to achieve knowledge of a reality which is assumed to be independent and objective through the actions of autonomous individuals (Leonard, 1997; Parker et al, 1995; Gordon, 1988; Loewenthal & Snell, 2003; Sarup, 1993). "The fundamental assumption of modernity is that knowledge can be based on primary processes in the 'real' world that are beyond and independent of the effects of discourses about them" (Leonard, 1997:11). Modernist thinking is also characterised as resting on what Lyotard (1984) termed 'grand' or 'meta-narratives' - the idea of history as progress, or "the progressive liberation of humanity through science, and the idea that philosophy can restore unity to learning and develop universally valid knowledge for humanity" (Sarup, 1993:132).

As a working definition Leonard (1997:5) defines "*postmodernity* as the period in which we are now living, the most recent stage in the development of late capitalism and *postmodernism* as the critical challenge to the universalistic knowledge claims of modernity and its belief in reason and progress". There are several ideas core to this critique. The first is a questioning of the meta-narratives Lyotard describes about

science and medicine; “I will use the term modern to designate any science that legitimates itself with reference to a meta-discourse…I define postmodernism as incredulity towards meta-narratives” (Lyotard, 1984:xxiv).

Foucault (1969:35) also questions “What, in fact, are *medicine, grammar,* or *political economy?* Are they merely a retrospective regrouping by which the contemporary sciences deceive themselves as to their own past?” and suggests that “their history is not the stone-by-stone construction of an edifice” (1969:62) as might sometimes be portrayed. He recognises that this questioning of previously held ‘givens’ inevitably leads to uncertainty, and that “Everything that was thought to be proper to the history of ideas may disappear from view. The danger, in short, is that…one is forced to advance beyond familiar territory, far from the certainties to which one is accustomed, towards an as yet uncharted land and unforeseeable conclusion” (Foucault, 1969:42). His history of the present (or genealogy), therefore, “is not an attempt to understand the past from the point of view of the present, but rather to disturb the self-evident present with the past” (Bunton & Peterson, 1997:4). The first postmodern criticism of the medical model might therefore be summarised as a questioning of meta-narratives such as the idea that through scientific method the nature and biology of man can and will be progressively revealed as matters of objective fact.

2.2.5.2 The role of language

As also briefly described in chapter one, a further key element of the postmodern critique of science and medicine centres on a questioning of the assumed direct links between meaning, language and reality. Saussure (1974: 67) first brought to prominence the idea that *“The linguistic sign is arbitrary”* (original italics) whereby “for Saussure, an individual element in language (a word, or a sound) is without intrinsic or ‘natural’ meaning. It has no meaning outside convention” (Loewenthal & Snell,

2003:64). Meaning, it is argued, is both subjective and subject to change over time and so “because meaning is continually slipping away from us, there can be no essential, certain meanings, only different meanings emerging from different experiences” (Leonard, 1997:10). Postmodernism therefore “not only highlights the ambivalence of meaning in language, but also demonstrates that understanding is mediated by the symbolic world of culture and tradition in which we exist” (Frie, 2003:137). This constitutes the second postmodern critique of the biomedical model - the notion that language simply represents an external objective reality is stripped away: as Foucault (1969:54), building on the ideas of Saussure and Lacan, wanted to “show…that in analyzing discourses themselves, one sees the loosening of the embrace, apparently so tight between words and things”.

Foucault does not therefore believe in modernist notions of an objective reality or independent truth, but seeks to understand the impact of truth claims made by competing discourses and how they construct subjects. For him, truths are “constructed ideas that are accorded a truth status - these “truths” are normalizing in the sense that they construct norms around which persons are incited to shape or constitute their lives” (White & Epston, 1990:19-20).

With reference to the medical model conception of human distress, as Parker et al (1995:1) put it “The terms we use are loaded with assumptions, and those assumptions are reproduced moment by moment in the practice of psychiatry…”. They go on to note that “What arises from these historical studies is the idea that the organisation of language is crucial to an understanding of mental ‘illness’. Language does not only organise reason but it also structures what we imagine to lie outside reason. It structures not only what we talk about but we imagine we cannot talk about” (Parker et al 1995:14). In the dominant discourse perhaps as Illich (1976:175) put it “Language is taken over by the doctors: the sick person is deprived of

meaningful words for his anguish, which is thus further increased by linguistic mystification".

Siegler & Osmond (1974:4) suggest that "…clinical medicine is best seen as a puzzling and poorly understood activity and should be approached anthropologically, as one would approach a religious ritual of some primitive people." They go on to argue that instead of "assuming that it is a conscious and rational activity, the rules of which are known to its practitioners, we should assume the opposite: that its rules are so deeply imbedded in human culture and lie so much outside awareness that its practitioners know as little about it as most of us do about the grammar and origin of our language".

2.2.5.3 Questioning the nature of reality

This brings us to the third element of the literature on the postmodern critique of the medical model in medicine – that based on a social constructionist perspective. From a review of the relevant literature the researcher has noted that there appears to be two distinct strands of thinking within this group – for the first (Foucault, 1969; Gergen, 1985; Lupton 1987 and Parker, 2008) medical knowledge is understood as "not simply as a given and objective set of 'facts' but as a belief system shaped through social and political relations" (Lupton, 1987:99). Disputing the idea that there is an objective reality that is simply uncovered by science, they argue instead that "through deconstruction we are able to see our knowledge and beliefs as historically and culturally specific products no longer able to be legitimated by reference to the universal authority of Reason, the transcendental guarantor" (Leonard, 1997:23). .

In the other strand (including Joseph, 2007; Maddux, Snyder & Lopez, 2004 & Maddux, Gosselin & Winstead, 2008 and Reznak, 1991) these arguments appear only to apply to psychopathology and not to medicine. Maddux et al (2004:321) are at pains to point out that "Unlike theories of physiological wellness and illness,

conceptions of psychological wellness and illness cannot be subjected to empirical validation. We cannot conduct research on the validity of a construction of psychological wellness and illness. They are *social constructions* grounded in values, not science, and socially constructed concepts cannot be proven true or false" – they do not therefore believe that theories of physiological wellness and illness might equally be socially constructed concepts.

Both of these strands highlight the issue of cultural relativism. As Parker et al (1995:1) suggest "The notions of madness and abnormal psychology as we understand them are particular and peculiar to our culture and our time." From Maddux et al (2008:11) "Our conceptions of psychological normality and abnormality are not facts about people but abstract ideas that are constructed through the implicit and explicit collaborations of theorists, researchers, professionals, their clients, and the culture in which all are embedded and that represent a shared view of the world and human nature." Clearly not everyone will agree about where the dividing lines sit between these ideas, but our power to be heard will depend on our position in society.

For Foucault and Lacan the clinical gaze can not only create subjects, but as a way of seeing the body, even *into* the body, it has the power to actually *constitute* the body. As Lupton (1987:99) puts it, "the body and its various parts are understood as constructed through discourses and practices, through the 'clinical gaze' exerted by medical practitioners". According to Sarup (1993:7) Lacan's "view is that biology is always interpreted by the human subject, refracted through language; that there is no such thing as 'the body' before language….he shows how culture imposes meaning on anatomical parts". How far, therefore, do the discourses doctors and therapists engage in with their patients/clients serve to create reality rather than reflect it?

2.2.5.4 Decentring the subject

Beyond a questioning of the grand narrative of progress through science, the representational nature of language and the nature of reality, the fourth element of the literature on the postmodern critique of the medical model questions the existence of an independent human subject, both as able to observe, measure and classify an objective reality which includes other human subjects as objects (Leonard, 1997) and in psychotherapeutic terms, able to participate in a process arguably focused on a 'self' or ego. This view, for Gordon (1988:21) is closely linked to the influence of ""individualism" – a complex of values and assumptions asserting the primacy of the individual and of individual freedom" in the development of the biomedical model. As Leonard (1997:xi) summarises, "Postmodernism challenges the modern idea of a universal, essential subject, common to all humanity".

In the biomedical model, the individual, the subject, is assumed to be an autonomous being acting independently of social forces. Even in "the softer humanist varieties the person is valued as the carrier of the symptoms. However, these are two sides of a process which individualizes distress, and treats it apart from social context" (Parker et al 1995:7-8). Discussing individualism Parker (2008:40) notes that, "Contemporary discourse is replete with words and images that locate the causes for our activities inside individual minds; we increasingly inhabit a 'psychological culture' that delimits the horizons of our inquiry". Social constructionists, however, view "subjectivity as a product of the social relations characteristic of a specific social formation at a particular point in history" (Leonard, 1997:34). The assumptions that participants may make about themselves and their clients, therefore, will give some clue as to the nature of the discourse being drawn upon.

For Foucault (1969:60), as mentioned in chapter one, the subject has no prediscursive existence; "discourse is not the majestically unfolding manifestations of

a thinking, knowing, speaking subject, but, on the contrary, a totality, in which the dispersion of the subject and his discontinuity with himself may be determined". He believed both objects and subjects to be products of discourse ("the object does not await in limbo the order that will free it…it does not pre-exist itself…it exists under the positive conditions of a complex group of relations. (Foucault, 1969:49)) and that in medicine "The power that doctors have in relation to their patients…might be thought of as a…means of bringing into being the subjects 'doctor' and 'patient' and the phenomenon of the patients 'illness'" (Lupton, 1987:99). The relevance of the literature which questions the existence of the subject beyond discourse is key: "In prosaic terms, if we cannot be sure of the investigator, there can be no investigation" (Heartfield, 2006:20), calling into question one of the central pillars of the modernist notion of science.

The literature considering postmodern critiques of the biomedical model has served to provide a counterbalance to that on the medical model itself, and shown some of the range of criticisms that may emerge from the empirical studies to be conducted, either directly from participants' contributions or via a subsequent analysis from the researcher. Having now considered the literature in relation to the research as laid out at the beginning of this chapter, the researcher will now move on to describe what options for research methodologies were considered and how a choice of method was made.

Chapter 3: Methodology and Method

This chapter covers both the journey to select an appropriate research methodology and then describes how it was implemented. The journey begins with some reflections on the nature of quantitative versus qualitative approaches to research (and their underlying philosophical assumptions) and then considers which qualitative method is most appropriate for this two part study into the potential influence of the medical model on psychotherapists working in either an explicitly medical setting (e.g. the NHS) or in private practice. The researcher then provides sufficient detail about the selected method to contextualise the implemented design. Finally, the researcher discusses ethical issues relevant to the research.

3.1 Quantitative versus qualitative approaches

Any researcher has the initial decision to make as to what type of research methodology will be chosen, quantitative or qualitative. This will be largely driven by the researchers' views on both ontology and epistemology where "epistemology concerns what it is possible to know whereas ontology concerns what there is to know in the world 'out there'" (Harper, 2012:87). Broadly speaking quantitative research is the option of choice for those working within a modernist, positivist epistemology, which "implies that the goal of research is to produce objective knowledge; that is, understanding that is impartial and unbiased, based on a view from 'the outside', without personal involvement or vested interests on the part of the researcher" (Willig, 2008:3). It is characteristically used by those working within an empiricist, scientific paradigm whereby "science progresses through a process of *conjectures* and *refutations*" (McLeod, 2003:5) and based on the idea that there is an objective reality of which it is possible to learn through experiment. As has been discussed in chapters one and two, "the fundamental assumption of modernity is that knowledge can be based on primary processes in the 'real' world that are beyond

and independent of the effects of discourses about them" (Leonard, 1997:11) and as such stems from a realist ontology which "maintains that the world is made up of structures and objects that have cause-effect relationships with one another" (Willig, 2008:13). There are those that argue (Gergen, 1985, Burman and Parker, 1993) that mainstream research in psychology has relied heavily on such beliefs and approaches, adopting "the view that the only knowledge worth having (or that it is *possible* to have) is derived from the prediction and control of (probabilistic) laws of behaviour" (Burman and Parker, 1993:158). Guba & Lincoln, (1994: 106-7) outline the key criticisms of quantitative approaches from both an intra- and extra-paradigmatic point of view. Amongst the former are the notions of "context stripping" where "precise quantitative approaches that focus on selected subsets of variables necessarily "strip" from consideration…other variables that exist in the context that might, if allowed to exert their effects, greatly alter findings" and the "exclusion of meaning and purpose". They go on to argue that "human behaviour, unlike that of physical objects, cannot be understood without reference to the meanings and purposes attached by human actors to their activities". Amongst the extraparadigmatic critiques they discuss are those which highlight both the "theory [and] value-ladeness of facts" (Guba & Lincoln, 1994:107) whereby "putative "facts" are viewed not only through a theory window but through a value window as well", undermining the possibility of real objectivity in such research.

As outlined in chapter one, the researcher is intending to explore psychotherapists' experience of the potential influence on their work of the medical model (which has been argued in chapter one and two to rest on modernist, realist philosophical foundations), and which seems in some ways to conflict with less modernist, more postmodern approaches to psychotherapy and counselling. The researcher is therefore interested to understand research methods based on alternative ontological approaches, more in harmony with postmodern ideas such as the questioning of the

role of language, history and culture in constructing reality and the place of the subject in any knowledge creating enterprise.

In considering alternative ontological positions the researcher noted that according to Willig (2008:3) there are few “unreconstructed positivists” left anyway and that Lincoln, Lynham, & Guba (2008) go on to describe a paradigm closely related to positivism of *post*positivism. According to them (2008:100) where, ontologically, positivists embrace a “naïve realism” ” in which there is a “real reality” (which is also apprehendible), postpositivism alternatively is deemed to embrace “critical realism” where reality can only be “imperfectly and probabilistically” apprehended. Epistemologically, where positivists would regard their findings as true, postpositivists would regard them as “probably true” (Lincoln et al, 2008:100).

As Gergen summarises, what researchers disagree about is the “extent to which our understanding of the world can approach objective knowledge, or even some kind of truth about the world”, with opinions ranging between the extremes of “naïve realism” and “rampant relativism” (Gergen, 1985:273). According to Willig (2008:13) relativist ontology maintains “that the world is not the orderly, law-bound place that realists believe it to be… [but] questions the ‘out-there-ness’ of the world and emphasizes the diversity of interpretations that can be applied to it”. A critical realist stance in her view therefore combines “the realist ambition to gain a better understanding of what is ‘really’ going on in the world with the acknowledgement that the data the researcher gathers may not provide direct access to this reality” (Willig, 2008:13).

As has been discussed in chapter two, social constructionism “draws attention to the fact that human experience, including perception, is mediated historically, culturally and linguistically. That is, what we perceive and experience is never a direct reflection of environmental conditions but must be understood as a specific reading

of these conditions" (Willig, 2008:7). Its associated research methodologies therefore could either embrace relativism or critical realism, depending on the importance placed on the existence of structures in the 'real' world.

On balance the researcher subscribes to the view that as Willig (2008:12) puts it, "there is no such thing as 'pure experience' and that the aim of research ought to be an explanation of the ways in which cultural and discursive resources are used in order to construct different versions of experience" (Willig, 2008:12). Given this belief and the researcher's intent to explore other therapists' experience, indeed, how they *construct* that experience through language it was quite quickly apparent that a qualitative research method would be the most appropriate to pursue as "qualitative researchers… are interested in how people make sense of the world and how they experience events" (Willig, 2008:8). Having made this choice, how did the researcher decide what qualitative methodology to use?

3.2 Qualitative Research Methodologies

The researcher first considered the options available from within phenomenological research methods because phenomenology is "the philosophical study of 'Being' (i.e. of existence and experience)" (Larkin and Thompson, 2012:102) - phenomenologists are therefore interested "in the nature of subjective experience from the perspective of research participants themselves" (Harper, 2012:89). Willig (2008:13) suggests that "there is a range of positions in-between the 'realist' and the 'relativist' endpoints of the continuum" and that one such is a phenomenological position that "argues that while experience is always the product of interpretation and, therefore, constructed (and flexible) rather than determined (and fixed), it is nevertheless 'real' to the person who is having the experience".

Larkin and Thompson (2012:102) explain that phenomenology is understood to have "two important historical phases: the transcendental, and the hermeneutic or existential", the former associated with Husserl, and the latter with both Heidegger and Merleau-Ponty. They suggest that for Husserl, "phenomenology was about identifying and suspending our assumptions ('bracketing' off culture, context, history, etc.) in order to get at the universal essence of a given phenomenon, as it presents itself to consciousness" (Larkin and Thompson, 2012:102). LeVasseur (2003:419) has suggested that, more simply, the "project of bracketing attempts to get beyond the ordinary assumptions of understanding and stay persistently curious about new phenomena." Husserl also introduced the concept of *intentionality*, described by Spinelli (2005:11) as "the first most basic interpretive mental act – that of 'translating' the unknown raw stimuli of the real world, which our senses have responded to, into an object-based (or thing-based) reality". As LeVassuer (2003:411) puts it, "In [Husserl's] view, consciousness was unified with its intentional object and could never be separate from that object. Husserl argued that it was the nature of human consciousness that it always be *directed*—that it is always pointed, as it were, toward something other than itself". This presented a very different view to that espoused by natural science which "correspond(s) to a belief in a lawful material world in which knowledge is separate from being" (LeVasseur, 2003:408).

The initial aim of transcendental phenomenology was therefore "to examine, expose and separate any difference between the appearance of things and what those things actually are (that is, the things themselves)" (Spinelli, 2005:10). These ideas are apparent in some of the "more descriptive forms of phenomenological psychology (see e.g., Giorgi & Giorgi, 2003)" (Larkin & Thompson, 2012:102). Whilst the researcher found Giorgi's method interesting, they had some doubts over his desire to work within a scientific framework (meeting criteria such as repeatability and interpersonal performance) (Giorgi, 2010) and how this would fit with a desire to find

a research method which offered a more postmodern approach. These doubts centred in particular first on the requirement to 'bracket' "one's natural assumptions about the world…so that what is essential in the phenomena of consciousness can be understood without prejudice" (LeVasseur, 2003:411) – as Scheurich (1995:240) puts it, a "postmodernist perspective suggests that the researcher has multiple intentions and desires, some of which are consciously known and some of which are not"; and second, that Giorgi's (2010:10) insistence that "100% of the data has to be analyzed and accounted for in the analysis whether the data appear to be relevant or not upon initial inspection" is, from a postmodern view (as discussed in chapter one) an attempt to reduce "the "wild profusion" of the Other (the interviewee)…to fit the modernist prison of the Same (the researchers' project)" (Scheurich, 1995:246-7).

The later form of phenomenology, hermeneutic phenomenology, (also referred to as interpretative phenomenology) allows the researcher "to go beyond the text and, instead, to interpret the experience and so render it more meaningful" (Harper, 2012:89). According to Larkin & Thompson (2012:101), "Interpretative Phenomenological Analysis (IPA; Smith *et al*., 2009) is an approach to qualitative analysis with a particularly psychological interest in how people make sense of their experience". IPA does not therefore aim for transcendent knowledge but draws instead on ideas from Heidegger and Merleau-Ponty which suggest that "persons (*Dasein*, 'there-being') are inextricably involved in the world and in relationships with others" (Larkin & Thompson, 2012:102). In IPA, therefore, "we are interested in understanding a person's *relatedness* to the world (and to the things in it which matter to them) through the meanings that they make." (Larkin & Thompson, 2012:102).

As the idea for the research arose from the researchers' own experience in working first as a therapist in a GP surgery and then setting up in private practice, the

researcher also considered the use of the phenomenological relational research method of heuristics - “a distinction of heuristics from other research methods is the explicit nature of the researchers’ involvement with the phenomenon that is being investigated” (Rose and Loewenthal, 2006:139). Such an approach would seek to “illuminate” (Moustakas, 1990) the question and really foreground the researcher’s own experience, putting “the researcher at the centre of the meaning-making process” (Rose and Loewenthal, 2006:141). As Rose and Loewenthal go on to ask, however, how might this be perceived from a postmodern perspective in which, as discussed at length in chapter two, the self is decentred and is subject to? Whilst it is true that all research methods involve an element of subjectivity, the researcher believed it to be more appropriate to seek a method which explicitly recognises the forces (language, social practices, the unconscious) to which individuals are subject.

As the researcher learned more about these options it became increasingly apparent that a method which engaged more with how meaning is *constructed*, specifically in terms of the importance of the social context, was felt to be a better fit both for the researcher and the research question selected. There was also the issue of the perceived dominance of the medical model in Western culture which meant the researcher wished to use a method which would help draw attention to the power relations at play. As Harper (2012:33) suggests, “for some researchers, the primary aim may not be to describe an empirical phenomenon, it may be to ask a question underpinned by certain theoretical preoccupations (e.g. …subjectivity, power) and/or drawing on particular theorists (e.g., Foucault…). Thus, one’s theoretical and, to some extent, political orientation is also a choice that needs to be made”.

With further reading it became clear that these ideas are well expressed in the ideas of social constructionism – research from this perspective is, according to Gergen (1985:266-271) “principally concerned with explicating the processes by which

people come to describe, explain or otherwise account for the world (including themselves) in which they live" – social constructionists are "are less focused on phenomena in themselves and are more interested in how the phenomena are seen" (Harper, 2012:90).

In his paper on the social constructionist movement Gergen (1985:266-271) explains that it challenges the idea of a direct connection between words and reality, pointing repeatedly to the importance of the "linguistic context", stressing that "The terms in which the world is understood are social artefacts, products of historically situated interchanges among people…the process of understanding is not automatically driven by the forces of nature, but is the result of an active, cooperative enterprise of persons in relationship" - as a consequence of this the "explanatory locus of human action shifts from the interior region of the mind to the processes and structure of human interaction. The question "why" is answered not with a psychological state or process but with consideration of persons in relationship" – social constructionists are therefore "critical of individualistic and intra-psychic approaches in the social sciences" (Harper, 2012:90). In addition, they are interested in "how some claims about reality are seen as having more validity than others" and that "different constructions have different social power" (Harper, 2012:90-1). The researcher wondered what kind of research method would enable these considerations.

There are two possible examples of qualitative research methods which fit with a social constructionist approach; the constructionist version of Grounded Theory espoused by Charmaz, 1990 (cited in Willig, 2008) and those associated with Discourse Analysis (which the researcher had first learned of through attending a series of lectures on research methods offered as part of the university's doctoral programme). In looking more closely at Charmazs' (2006:19) ideas her approach "explicitly assumes that any theoretical rendering offers an interpretive portrayal of

the studied world, not an exact picture of it. Research participants' implicit meanings, experiential views—and researchers' finished grounded theories—are constructions of reality". In taking this view Charmaz successfully counters one of the major criticisms levelled at Glaser and Strauss' original formulation of Grounded Theory that it "pays insufficient attention to the role of the researcher" and relies on an inductivist epistemology whereby "observations give rise to new ideas" (Willig, 2008:46).

In reading more about the development of Grounded Theory it became clear to the researcher that it was primarily designed to facilitate the study of "fundamental social or social psychological processes within a social setting" (Charmaz, 2006:14) rather than an exploration of a range of experiences. Whilst Grounded Theory has been used in psychology to categorise research participants experiences, according to Willig (208:47) "such a mapping of experiences is a *descriptive* rather than an *explanatory* exercise and, as such is not geared toward the development of theory". She goes on to suggest that perhaps Grounded Theory should be reserved for the "study of social psychological processes" (Willig, 2008:47), a suggestion perhaps based on Charmaz's (2006:17) own declared intent to "return to past grounded theory emphases on examining processes". In this respect the researcher wondered how suited Charmazs' method would be to research questions aimed at exploring therapist's experience of the influence of the medical model on their work – to what extent were social *processes* at play? Charmaz (2006:18) usefully defines a process as consisting of "unfolding temporal sequences that may have identifiable markers with clear beginnings and endings and benchmarks in between. The temporal sequences are linked in a process and lead to change. Thus, single events become linked as part of a larger whole" and gives an example as "a study of how newly disabled young people reconstruct their identities" (Charmaz, 2006:14). Whilst the researcher could see that there might be various social processes involved giving

rise to experiences (for example how a patient reacts to being ‘diagnosed’ with a ‘mental health condition’ or how psychiatrists react to their patients also choosing to work with a psychotherapist) it was not the intention to try to isolate any one of these processes and study it, but to potentially understand what range of social processes (and their discourses) might be at work. In considering discourses, Willig (2008) suggests that the social constructionist version of grounded theory might also need to do more than just recognise the active role of the researcher and take *language* more into account, to “theorise the role of language in the construction of categories, which in turn would mean engaging with the notion of ‘discourse’” (Willig, 2008:46-7). It therefore seemed appropriate for the researcher to consider what discourse analysis itself might have to offer.

So what is a discourse analytic approach? According to Georgaca and Avdi (2012:147) it “developed out of the ‘turn to language’ in social psychology in the 1970s and 1980s and the emergence of social constructionism”. It terms of its use as a research method Willig (1999:1-2) noted that “In recent years discourse analysis has become an increasingly popular research tool in psychology (e.g. Potter and Wetherall 1987; Edwards and Potter 1992; Parker 1992; Burman and Parker 1993; Butt 1995)”, with Hook noting just two years later that “There can be little doubt that discourse analysis has come to represent something of a 'growth industry' in research psychology. Indeed, there has been, together with a proliferation of the various models of the process of discourse analysis (cf. Bannister, 1995; Fairclough, 1995; Parker, 1992; Potter & Wetherall, 1987) a veritable explosion of discursive analytic work” (Hook, 2001:1).

In her consideration of the introduction of the particular form of discourse analysis espoused by Parker (1992), Foucauldian discourse analysis, Willig (2008:112) noted the significance of the publication of the book 'Changing the Subject: Psychology,

social regulation and subjectivity' in 1984. Since that time she comments that it has become "a highly influential publication which inspired many discourse analytic research projects including doctoral theses throughout the 1980s and 1990s".

It should be recognised, however, that to some, the use of discourse analysis might be regarded as unorthodox on perhaps two levels: first, whilst it has grown significantly in popularity, its use remains less common than that of other methods. In its defence, according to Gerogaca & Avdi (2012:159) “Over the last two decades much discourse analytic work has been carried out in the field of psychotherapy” and they usefully produced a review paper in 2007 in which they “attempt to organize studies which employ discourse analysis to examine psychotherapy process, with the aim of rendering the existing literature more accessible to researchers and therapists (Avdi & Georgaca, 2007:158). Second, this method may be regarded as unorthodox because it raises a direct challenge to conventional forms of research in psychology and questions any approach that starts with a hypotheses and tests for it. “In its method psychology has helped to make its objects of study into the kind of ‘subjects’ who can be known, so the stakes of control and resistance are much more than simple images of what people are. This means that *radical research in qualitative psychology is the subversion and transformation of how we can come to know more about psychology*” (original italics) (Parker, 2005:1). Specifically in terms of research in psychotherapy such methods are used to move from the looking at the “construction of therapeutic discourse to its *deconstruction*” (Parker, 1999:1)

Taylor and Loewenthal (2001:66) suggest that it is this method which “comes closest to offering a research method in a postmodern world. However, it is an approach rather than a method”. Burman and Parker (1993:2) argue that “In so far as there could be said to be commonality, these approaches are united by a common attention to the significance and structuring effects of language”. A discourse is

variously defined as "*a system of statements which constructs an object"* (Parker, 1992, Ch1:2), "linguistic systems of statements through which we speak of ourselves and our social world" (Leonard, 1997:2) and "shared patterns of meaning" (Burman and Parker, 1993:1). In discourse analysis, therefore, what is said is analysed in terms of how *objects* and *subjects* are spoken of, how they are *constructed* by how they are spoken of.

The reason that discourse analysis can only be described as "coming the closest" to a postmodern friendly methodology is that the central ontological debate in this field remains how far, if at all, such discourses reflect objects that have an independent existence outside of that discourse (given that they are constructed *by* the discourse). According to Scheurich (1995:240-1) it is still common to find qualitative methodologies working on modernist assumptions such that it is possible to accurately represent either the real experience of the participant or the data collected; "The claim of accurate or valid representation, especially in terms of such techniques as line numbering, identification, and quantification of comparable-meaning monads, statistical techniques, or even discourse analysis simply serves to hide the overwhelming absent presence of the researcher and her or his modernist assumptions [about selves, language, and communication]". He goes on to suggest that there is a "startling lack of discussion about the unresolvable ambiguities of consciousness, language, interpretation, and communication. From a postmodernist perspective, this severe modernist reduction of the exquisiteness of each lived moment borders on a kind of violence" (Scheurich, 1995:242) and this will be discussed further in chapter five. Potter and Wetherall (1987:49) contend, however, that "We do not intend to use the discourse as a pathway to entities or phenomena lying 'beyond' the text. Discourse analysis does not take for granted that accounts reflect underlying attitudes or dispositions and therefore we do not expect that an

individual's discourse will be consistent and coherent. Rather, the focus is on the discourse *itself*: how it is organised and what it is doing".

Parker (1992, 1995), on the other hand, identifies himself as a 'critical realist' by arguing that "our knowledge of the world is necessarily mediated by, and therefore constructed through language… while maintaining that there are underlying structures and mechanisms that generate phenomena, versions of which we then construct through language…This means that discursive constructions of reality are not free-floating but that they are grounded in social and material structures such as institutions and their practices" (Willig, 2008:130). Otherwise, according to Burman and Parker (1993:160) "discourse analysis may be in danger of mistaking discourse as the sum total, rather than the manifestation of, structural relationships". As Harper (2012:92) notes, researchers adopting a critical realist social constructionist approach "take the position that, alongside an awareness of the importance of studying qualitative data in detail, it is also important to go beyond the text in order to add a further layer of interpretation – by setting what is said in a broader historical, cultural and social context".

The researcher considers this debate to be central to the research question – how far are social structures such as the NHS, GP surgeries, third party funders and their 'practices' to be considered as independent sources of the experience which participants may construct accounts of in interview? If they *can* be considered as independent sources, then how far might a participant be able to exert their own agency in the face of the dominant discourses which construct such sources, or will those discourses actually shape the participant's sense of self (how far is the participant 'subject to'?)

Having concluded that discourse analysis was the most appropriate methodology for this research, the researcher has then considered the different approaches available.

3.3 Approaches to Discourse Analysis

As the two approaches representing "perhaps the two most prominent 'schools' of discourse analysis in psychology" (Hook, 2001:1), the researcher compared the approach outlined by Potter and Wetherall (1987) with that of Parker (2005) who, as mentioned above, has developed and advocated the use of a more Foucauldian approach to this methodology which pays attention to how dominant discourses may support and enable, or oppress and disempower, particular groups in society by considering power relationships and the "material conditions within which such experiences may take place" (Willig, 2008:113). Foucauldian discourse analysis also encompasses a historical analysis (or genealogy) of how current discourses have come to be and how such discourses construct subjects. Potter and Wetherall's approach is more focused on the specifics of language used within a text – how it functions, what it does, what purpose it serves. As apparent relativists, whilst they are also looking at how "people are using their language to *construct* versions of the social world" (Potter and Wetherall, 1987:33), there is less emphasis on looking at power relations and the possible influence of independent social structures.

In the context of this research question, therefore, the idea of pursuing a Foucauldian approach was attractive because of its focus on power (what might the power relationship be between a dominant 'medical' discourse and that of non-medical model counselling modalities?) and on the possible role of independent 'material structures' in the social landscape and their associated discourses (Willig, 2008) (for example, as discussed in chapter two, Foucault's focus on the institutional location of doctors 'gaze' and the notion of the location of discourse being *exterior* to individual consciousness).

One final attraction of Parkers' approach is his desire to inspire radical research that is action oriented - whilst there are clear limitations in terms of what can be hoped for

in the context of this piece of research, it is not unreasonable to consider the possibility it may ""build the capacity of those involved to take action" (Morrow, 2005:545 citing Patton, 2002).

His method has been published and well documented over the last twenty years with many researchers having now used his approach, including Soal & Kottler's 1996 study of narratives in family therapy, Willig's 1999 exploration of sex education, Harper's 1999 study using discourse analysis to explore "the ways in which talk about [psychiatric] medication construct a number of subject positions for users and professionals" (Harper, 1999:125) and Shaw & Greenhalgh's 2008 exploration of research in primary care to cite a few. His method has also been critiqued extensively perhaps most famously by Hook (2001:1) who takes issue "with erroneous (mis)-applications of Foucault's concept of discourse by attempting to re-characterize a Foucauldian perspective on what discourse is, and on what a sound discursive analytic methodology should entail" which is discussed further in chapter five.

Before going into detail on Parker's methodology, is it worth noting that both Potter and Wetherall (1987), and Parker (1992) comment that their respective suggestions of steps or stages represent an outline of an approach rather a prescriptive framework to be applied sequentially.

3.4 Methodological Approach and Implemented Design

What follows is an overview of the methodological options and suggestions made by Parker (1992, 2005) along with confirmation of the actual design implemented by the researcher. The detail of his 20 possible steps are summarised for clarity and brevity in Appendix A.

3.4.1 Preparation, Participant Recruitment and Selection

"First element of technique – the interviewee as co-researcher is enrolled as a discourse analyst (Parker, 2005:95). A discourse analysis can start from *any* piece of text (for example, an advert or a bus ticket). Parker (2005:95) suggests that a research interview can be regarded as "a *text-in-process*" and the researcher chose this option. Parker recommends that each participant is interviewed *twice* and the rationale for this will be discussed further under the fourth element of technique and critiqued in chapter five.

As preparation for the first interview, Parker (2005:94) suggests that the researcher should have considered such questions as "why you chose this topic, what stake you have in it, why you may want to question it, and what theoretical resources might be useful" and these have therefore been considered in chapter one. As also explained in chapter one, the overall study has been designed to explore the potential influence of the medical model on psychotherapists working in either an explicitly medical setting (e.g. the NHS) or in private practice. This was operationalized into two distinct primary interview questions; for part one, "Is the medical model infectious? How, if at all, is psychotherapy provided in a GP surgery affected by the relationship a patient has with their GP?" For part two, "How, if at all, does medical model thinking influence or enter your work in private practice?"

Parker (2005:94) also highlights the need to have "determined that your co-researcher is also interested in questioning those issues and that they will be willing to engage in the additional task of helping you question their own discourse analysis". This, alongside the need for a second interview, was therefore factored in to the approach to participants which was conducted as follows.

Recruitment and Selection of Participants

As detailed in the appropriate Ethics Applications (see section 3.5.2 and Appendix B), the researcher contacted a range of personal contacts soliciting participants. The criteria for selection for the first part of the study were that a prospective participant could confirm that;

(i) they had had at least six months experience of delivering psychotherapy in a GP surgery *and* that

(ii) their theoretical orientation was one which *does not* embrace the medical model / metaphor for psychotherapy (e.g. person-centred / humanistic)

Six people contacted the researcher following the initial email recruitment campaign and it was confirmed that they had all received a copy of the briefing document, understood the nature and timing of the commitment required and met the selection criteria. This contact included an overview of the need for two research interviews and drew attention to the role the participant would need to play (Briefing Document in Appendix B).

For the second part of the study the criteria for selection were that they could confirm that they;

(i) have had at least one year's post qualification experience delivering psychotherapy in a private practice setting and

(ii) currently *only* work in private practice and

(iii) be accredited by a recognised body (BACP, UKCP, IPN Member or similar) and

(iv) be interested in talking about issues relevant to the research question

After advertising for participants via a range of email contacts, the BACP on-line research student noticeboard and at a UPCA conference, the researcher had eight

people respond and as above, all administrative requirements of the ethics application were met.

As each participant would be interviewed twice the researcher selected eight participants in total across both parts of the study partly on a purposive basis based on the criteria given above ("to provide the most information-rich data possible" (Morrow, 2005:255)) and partly on a convenience basis in terms of availability for interview, as it was felt this would give sufficient data and be realistic in the time available for research on each occasion. As the researcher had no pretensions to generalizability there was no question of trying to ensure that the participants were representative of psychotherapists in general. This is discussed further in chapter five. See demographic table below reflecting the information available to the researcher on selection.

Table 1 - Participant Demographics

Participant	Gender	Modality	Accreditation Status	Relevant experience
1	F	Humanistic / Gestalt	Trainee / MBACP	At least 6 months experience in a GP surgery
2	M	Person Centred	Trainee / MBACP	
3	F	Integrative / TA	Trainee	
4	F	Humanistic / Gestalt	Trainee	
5	F	Existential	UKCP Accredited	Min 1 year's post qualification experience in private practice Not also currently working in a medical setting
6	M	Existential / Psychodynamic	IPN Participant	
7	F	Jungian	UKCP Accredited	
8	M	Gestalt	UKCP Accredited	

3.4.2 First Interview – Structure and Implementation

Parker (2005:93) suggests that the first interview be semi-structured and should facilitate the participant to "elaborate socially shared material connected to the text through a version of free association" (at this stage, the 'text' is effectively the

research question). This is followed by a focus on the *objects* mentioned in the emerging text-in-process (the interview) in terms of both their significance and how they are talked of; “the object that a discourse refers to may have an independent reality outside discourse, but is given *another* reality by discourse” (Parker, 1992, ch1:5).

It would also seek to cover the “*Second element of technique – the discourse itself is made to speak, and the analyst sees it at work” (Parker, 2005:95).* This is achieved first through a focus on the *subjects* which have arisen in the text, by “specifying what types of person are talked about in this discourse,” (Parker, 1992, ch1:6) and considering “what else may be said by subjects in the text” (Parker, 2005:93). Second, the researcher should aim to facilitate the interview in spelling “out the networks of relationships” (for example power relationships), in the text.

Finally, it would cover the *“Third element of technique – a point of contradiction and space against the discourse is highlighted” (Parker, 2005:93-96).* The researcher should enable the interviewee to “speculate as to how the characters positioned in relation to one another would deal with objections from ‘outsiders’”, or “ways in which a discourse disallows and discredits ways of speaking outside its own frame of reference, outside its own version of the world” (Parker, 1992, ch1:7). They should also seek to contrast “the ways the same ‘object’ is positioned in contradictory ways of speaking”.

The researcher therefore created an interview plan to cover these points and a copy of this is included as Appendix C. Each interview was conducted according to the plan (having first got the participant to sign the agreed consent form) and relevant examples will be given in chapter four in which the findings of the research are presented. The participants were suitably debriefed and arrangements made for second interviews to take place, three-four weeks later.

3.4.3 The Initial Analysis

Between the two interviews, the researcher enters the first phase of analysis, the final one taking place after the second interview. In both phases, Parker (2005:89-90) suggests that the researcher should apply an analytic framework based on:

(i) **Multi-voicedness:** "instead of searching for underlying psychological process or themes" this explicitly listens for the contradictoriness of people's experience. Whereas other research methods might wish to ignore or underplay these, in discourse analysis "this variability marks points of contradiction that need to be taken seriously".

(ii) **"Semiotics,** by which we mean the way we put language together in discussions and other kinds of text…At the same time as we actively form sentences…, we also have to use words and phrases that carry meanings we cannot entirely control".

(iii) **Resistance:** Third, he suggests the researcher should look for uses of speech that represents "*resistance.* Language doesn't only describe the world, it does *things*. Innocent comments may carry a force of blame or complaint or indirect request…."

(iv) **Potential Discourses:** these he defines as being "a chain of words and images…the organisation of language into certain kinds of *social bond* and each bond includes certain kinds of people and excludes others". In order to do this, Parker (2005:98) suggests that the researcher decide "what kind of theoretical stuff is going to get this motor running, and whether it is drawn, for example, from work on gender, sexuality, race or class as relevant axes of power". He then advocates that the researcher "soak what you have [the text-in-process] in this resource, and use it to organize what you now see in the text".

The researcher should then start to make some choices about the categories they wish to use (these should derive from the theoretical resources selected - they "might be ideological images structuring the text or aspects of control and resistance") and use them to "read and frame the whole text".

The theoretical resources selected for this study were; medical knowledge / expertise / practices as a primary power axis for analysis; the presence or absence of a medical discourse in relation to conceptions of human distress and counselling; and notions of autonomy versus heteronomy.

Each interview was transcribed by the researcher using a variation of the transcription convention developed by Jefferson, as detailed by Madill & Barkham (1997) (see Appendix D). They were then analysed using the analytic framework described above. Following Parker's (2005:98) recommendations the researcher then grouped what emerged through immersion in the data into relevant categories (an example being 'the discursive construction of the heteronomous patient').

Parkers approach suggested that these categories should then be discussed with the research participant at a second interview, making clear how they were arrived at, to see what they make of it – as the text is still 'in process' during this second session, points of difference should be discussed and clarified.

3.4.4 The Second Interview -Structure and Implementation

The second session covers steps 11-12, the: *"Fourth element of technique – the analysis is made visible to the co-researcher" (Parker, 2005:96).* In this interview the researcher and participant "name some 'discourses' as the kinds of social bond that makes the contradictory arrangements between the subjects possible" (Parker, 2005:94) or "Reflect on the term used to describe the discourse" (Parker, 1992, Ch1:10). As Scheurich (1995:246) notes, most of the time "respondents have no

opportunity to comment upon interpretations of their words and intentions. This way of doing research takes away from respondents their right to "name" their world". This issue is addressed in this second interview.

In his earlier work Parker (1992:Ch1:10-13) details seven more possible steps which are also shown in Appendix A. Of these the researcher decided to include steps 15-18 which "identify institutions and groups of people which are reinforced or attacked when this or that discourse is used" and looks at "who would want to promote and who would want to dissolve the discourse". Whilst step 13 ("how and where discourses emerge") was not covered in interview, the information included in the literature review concerning the development of the key discourses has inevitably informed both the analysis in chapter four and discussion in chapter five.

The researcher created an interview plan for this second stage (see Appendix C) and interviews were conducted in line with it – issues regarding the relative success of this will be discussed in chapters four and five. Again, participants were appropriately debriefed and thanked for their participation.

Before moving on to describe the method recommended and implemented for the final transcription and analysis, it is relevant at this point to mention reflexivity, specifically in connection with the role it played in the second interviews.

Willig (2008:10) suggests that *"reflexivity* requires an awareness of the researcher's contribution to the construction of meanings throughout the research process". Parker (2005:25) takes this idea further in terms of his critical realism stance in suggesting that "reflexivity is a way of *attending to the institutional location of historical and personal aspects of the research relationship".* Specifically, the researcher needs to consider the role they will play in constructing meaning, as Morrow (2005:253) questions, "the extent to which there is a mutual construction of

meaning …between and among researcher and participants, or co-researchers." There are two components to this role – the first is that by taking the initial analyses back to the participant the researcher strives to increase the chances that meanings drawn are mutual, although this will be discussed further in chapter five.

The second aspect is the active consideration by the researcher of the impact of their positioning in terms of theoretical orientation, philosophy and politics on the meanings drawn and discussions held. It is important to mention this specifically as part of Parker's (2005:35) suggested method is that reflexivity "should not be a self-indulgent and reductive exercise that psychologizes phenomena and psychologizes your own part in producing them. Instead the reflexive work is part of the action and in action research much of that reflexive work is undertaken alongside and in collaboration with co-researchers". The researcher consequently did not shy away from locating the research philosophically and politically with a participant during one of the second interviews when it was of relevance.

3.4.5 Final Transcription and Analysis

The second interviews were transcribed using the same conventions as the first interviews yielding a total of nineteen hours and forty-eight minutes of data. The transcripts were then subjected to a final phase of analysis. This included producing summaries of emerging discourses that appropriately reflected the content of both interview sessions for each participant. The researcher is particularly conscious that as far as any 'final' analysis is concerned "We can never come to the end of the meaning of a text, because there will always be another perspective on it, a new horizon will come into view." (Taylor and Loewenthal, 2001:71).

Having completed the analysis for each participant the researcher considered what types of discourse, if any, appeared in more than one participant's transcripts (within each study rather than across both). The connected groups of discourses that

emerged from this review have formed the major part of the structure of chapter four, which details a selection of the research findings for each study in turn. Potential similarities or significant differences between discourses across both parts of the study have been highlighted in the presentation of findings for part two and are discussed further in chapter five.

In line with Parkers' method, these are described in terms of how the researcher and participants saw subjects and objects constructed through discourse and are presented where relevant in terms of their relationships and institutional context. As Burman and Parker (1993:2) explain, "discourse analysis offers a social account of subjectivity by attending to the linguistic resources by which the socio-political realm is produced and reproduced". As has been discussed, Parkers' (1998:2) stance of critical realism promotes an understanding of how "subjectivity is discursively reproduced within present social arrangements" and so potential connections to relevant structures and mechanisms have been drawn.

The findings also include references to the results of chapter two, the literature search, as "some awareness of cultural trends, of allusions to political and social developments, is essential for a discourse analysis to work. If you do not know what a text is referring to, you cannot produce a reading" (Burman & Parker, 1993:157-161). It is therefore essential where possible, to locate discourses culturally and historically, and reflect the fact that discourses are not fixed –"It is necessary for discourse analysis to theorize fluctuations and transformations in discursive relations to ward off a reading of them as unchanging".

Finally in this chapter the researcher recognises the importance of having considered questions of ethics in regard to the research and outlines what areas were given such consideration.

3.5 Ethics and Procedure

3.5.1 Doing justice to the participant

When thinking through the ethical considerations for this research, the researcher was much influenced by the philosophy of Levinas (1989), in particular the idea of doing justice to the participant at each stage of the research rather than adopting a more formulaic approach. The first application concerns participant anonymity.

Parker (2005:17) considers his methodology to offer an option for radical, action oriented research – a key element of this is that it attempts to give a voice to those normally silenced by mainstream discourses. He therefore suggests that "…rather than take this anonymity for granted as a solution to ethical problems…it is better to treat anonymity as an ethical *question*." Whilst this idea appealed to the researcher very much it was reluctantly concluded that given the time constraints for this piece of work it would not be feasible to offer participants the option of being identified in the final report, as it would have meant allowing them the option of withdrawing *after* the report had been substantially written up.

The second aspect for which the idea of doing justice by the participant was relevant concerned their ability, as therapists, to deal with any issues which arose from the research interviews. On the one hand, "the tendency to highlight the need for third party intervention has implications for agency and empowerment….[which] are being compromised by the tendency to assume vulnerability" (McLaughlin, 2003:47). On the other, as part of the researchers responsibility to the Other, how far was it reasonable to assume a participant might *not* be vulnerable? It was therefore decided to ask participants whether any issues had arisen for them and to offer peer support in seeking help should that be required.

Finally, a third aspect arose during both stages of analysis and during the write up of this report - "whether or not the interpretations that are being elaborated in the report

lie within the terms of the commitment that was made to the co-researchers" (Parker, 2005:34). The researcher has sought to ensure that this commitment has been honoured, seeking both to avoid the temptation whereby "Identical and non-identical are identified. The labour of thought wins out over the otherness of things and men" (Levinas, 1989:78), and to ensure that difference is identified rather than criticized. As Morrow (2005:252) comments in her discussion of the notion of trustworthiness in research, "*Fairness* demands that different constructions be solicited and honored". This will be further discussed in chapter five.

3.5.2 Ethical Approval & Procedure

Two separate ethics applications were approved by the relevant School Ethics Committee which summarised the nature and intent of each part of the study respectively. These applications also considered the management of risk and confirmed data would be stored and handled in conformance with the relevant university guidelines. These plans have been followed by the researcher and copies can be found as Appendix B.

In this chapter the researcher has described how they arrived at the selection of Parkers' (2005) Discourse Analysis influenced by Foucault as the research method for this research and then described specifically how the method was implemented. The researcher has also discussed ethical issues considered before, during and after the research was conducted. In the next chapter the researcher will present the research findings.

Chapter 4: Analysis and Findings

This chapter describes the findings of the research conducted into the questions which comprise this two part study which are: "*Is the medical model infectious? How, if at all, is psychotherapy provided in a GP surgery affected by the relationship a patient has with their GP?"* and "*Exploring the influence of the medical model discourse on psychotherapists working in private practice"* which, as outlined in the previous chapter was operationalized as the question "*How, if at all, does medical model thinking influence or enter your work in private practice?"*

In the last chapter the researcher described the stages of Parker's (1992, 2005) approach to Discourse Analysis used in both parts of the study. The analysis was composed of three stages; first, the material from the first interviews was analysed using the framework described in 3.4.3. An example of the output of this analysis can be found as Appendix E. The researcher then fed back the discourses they saw as a result of this to participants at the second interview using the method described in 3.4.4. Last, a final stage of analysis was completed which reflected the output of both sessions and generated discourse summary tables for each participant. An example is included in the presentation of findings below with further examples available in Appendix F. (Whilst these serve to provide a connection back to the original data, it should be borne in mind that the researcher has also considered the ways in which the discourse constructs meaning *beyond* that necessarily intended by the participant.)

The findings, drawn from these summary tables, are presented as a total of seven sets of discourses relevant to the questions asked (four sets relating to the first question, three to the second). The findings are presented for each part of the study separately, starting with those associated with part one.

4.1 Part one: The discursive 'frame' for primary care counselling

Whilst in general the findings reveal a diverse range of discourses, all of the participants referred to elements of a social and institutional structure that framed their delivery of therapy. This served to provide an *object* position for primary care counselling.

Counselling was positioned as being part of an overall system comprised of primary and secondary care medical services. A patient visits their GP as a "first port of call" (C: 1/547) whose role it is to then assess patients' needs and route them as appropriate to a range of medical services available on GP referral (primary care services), including counselling. If the patient's needs are deemed sufficiently serious then the GP may choose to refer them directly to secondary care services, for example to a consultant psychiatrist.

All participants talked of clients being 'assessed' using a standard questionnaire ("the CORE system puts it all in numbers" (A: 1/325)) with particular focus being placed on the 'risk' factors (questions involving self harming or intent to harm others). Participants who were trainee therapists talked of only being assigned clients who had low CORE scores: "that's the nice aspect of it that it is known in advance what the score is and therefore it's known that this should be ok for a trainee counsellor" (B:1/115-6). As discussed in chapter two the preference for numerical evidence is regarded as a major feature of the biomedical model. The same participant went on to recognise, however, that clients "do misread questions and get things wrong" (B: 1/129).

When a trainee is out of their depth participants were clear that they can "bounce" (A: 1/303) the client back for re-referral "you know as a counsellor, I can pass that responsibility back" (D: 1/239) with the GP being seen as "the responsible clinician" (D: 1/250).

Counselling in primary care was therefore constructed as dealing with “anxiety and lower end scale problems” (C:1/253) with “perhaps more psychotic problems, manic depression, you know, they would be secondary care” (C:1/256-7). Psychiatrists are positioned as being “very much qualified in seeing a client, listening to them, I think they do do counselling as they're listening to them and drugs - drugs, drugs, drugs - that's what it's all about juggle the drugs” (C:1/189-91).

From three of the four participants there was a superficial, initial discourse, therefore, about counselling as a ‘medical’ service, having a clear place within an overall continuum of ‘medical’ care in the structure of the NHS. The researcher sees this as linked with a particular version of the subject position of the ‘heteronomous counsellor’ - in which the counsellor is subject to both the power of the doctor and the system – and this will be expanded on later.

A specific part of the interview involved thinking about who gains and who loses from particular discourses and it was felt that both patients and people who worked in the system benefitted from this overall discursive frame, as it gave them a “‘place and a function and a purpose inside that system”(Researcher C:2/170). Some participants could not however see anyone who might lose from the discourse; the researcher suggested that there might be those who operate outside the system, in a non-medical model way, and that they might be disadvantaged by such talk but there was no real recognition that such a group might exist (“yeah, I suppose” C:2/182).

An alternative meaning framework was, however, introduced by a participant who used the metaphor of the counsellor as being a “cuckoo in the nest” (B:1/23-4) of the surgery, referring to the temporary nature of their presence as a trainee counsellor; “I do feel like a temporary visitor, I don’t feel *part* of it” (B:1/358). The participant went on to talk about how they were finding it difficult to find a room suitable to conduct counselling that’s “free of people, free of clutter” (B:1/577), that wouldn’t be invaded

by other staff. There was a clear resistance to criticise the surgeries “they’ve all been very welcoming” (B:1/ 253-4), but it remained a fact that the counsellor’s fundamental need for a private, quiet, contained space had not been met – perhaps in the way that a real cuckoo’s needs are difficult for the host to accommodate and indeed requires some kind of sacrifice.

When reflecting on the use of this metaphor in the second interview the participant was horrified at the idea that the ‘cuckoo’ counsellor might disadvantage the surgery’s own ‘chicks’, offering a clear example of semiotics, where there are “words and phrases that carry meanings we cannot entirely control”(Parker,2005:89).

This participant went on to say that whilst they were now used to the idea of counselling being delivered in a GP surgery, it was *not* an association they would have made previously: “I personally I just associate doctors with bodies – I *know* different now but I’m talking very generally – doctors deal with [.] things that go wrong with bodies, um so if you’ve got something wrong with your mind you’re absolutely stuck, because you don’t know where to go, you don’t know who can help you and you wouldn’t think to go to your doctor” (B:1/497-501).

Overall, therefore, primary care counselling was positioned as being embedded in the medical system (whether logically or not) with frequent uses made of medical discourse language (“mental health problems”, “serious personality disorders”, “diagnosis”), and with clients frequently referred to in object-like terms; by diagnostic labels such as ‘OCDs’ or ‘the borderline’ (A: 2:251); of being able to “bounce” clients back to the referring doctor when a referral had been inappropriate. It was also suggested that clients can be viewed as ‘appointments’ (A: 2/387). It was recognised that clients lose from this discourse “because the human aspect kind of goes - they are a number, and they are using up a time slot” (A: 2/398), but it was thought that by treating the clients as time slots “counsellors gain because it becomes manageable”

(A: 2/395). This was felt to be a necessary evil in order to manage the waiting list effectively.

As the interviews progressed however, and the researcher questioned what was meant by some of the terms used, other discourses emerged about how far the 'system' often doesn't work as it is supposed to, with GP's sometimes not fulfilling the role described for them and with secondary care not always providing a consistent or helpful service to clients; "my client's experience of secondary health care was dire again" (C: 1/202) – a set of 'unofficial' discourses emerged which the participants all displayed various levels of resistance in describing and these will be expanded on later.

Within the context of the overall official set of discourses about the 'system' of primary care counselling the researcher found five relevant discourses about the key subjects involved – the GP, the patient/client and the counsellor. These are now presented in two sets, sorted in terms of their relational partners.

4.2 The heteronomous counsellor, patient and the GP as the 'God in White'

Before the researcher describes the discourses around the GP/patient relationship in this set of three, it has become apparent how important it is in terms of context to understand the subject position of the counsellor in relation to the GP– it is after all *their* discursive view of the GP/patient relationship which has been researched.

4.2.1 The heteronomous counsellor

In this discourse counsellors (and particularly trainee counsellors) are described as having a very prescribed role with limited authority; "as a trainee I don't have the authority to make any decisions" (B:1/111-2), "all the paperwork is done by the doctor" (A: 1/304-5) and are clearly often subject to the authority of GPs/doctors and

senior counsellors. In one case participant A had agreed that “I will not do anything without discussing it with the doctors” (A: 1/114).

Three of the four participants referred on several occasions to their relief that they could refer a client back to a GP who held overall ‘clinical responsibility’ and who could refer on into secondary care or otherwise take back responsibility for a client/patient. The heteronomous counsellor is not only subject to the power of the medical system in this position, but *pleased* to be so (A/2-445-7). As participant D put it “they’re the responsible clinician [.] sometimes I look at them at them and think, God, how do you guys sleep at night?” They *want* to believe in their infallibility “I thought because the doctor referred him to me, I thought it will all be ok” (A: 1/78-9).

One of the participants, however, whilst initially having used terms to describe her experience as a trainee counsellor such as “I am kind of their servant” (B:1/367), “I suppose I felt rather disempowered” ((B:1/329), “I don’t think the GPs necessarily understand what us trainees do, or what our status is or anything, really” (B:1/286-7), could not recognise the discourse of the counsellor who is ‘subject to’ when discussing initial conclusions at the second research interview. This was because during the four weeks that had elapsed between interviews the participant had completed her training and had since been employed as a qualified counsellor; “so from being a trainee last time I spoke to you, or even a trainee last week, um I'm now somebody else um, who supposedly who has more clout” (B:2/264-6). This serves to illustrate the idea that discourses are not static, that, in critical realist terms, they are “manifestations of structural relationships” (Burman and Parker, 1993:160).

4.2.2 The GP as the ‘God in White’

For participants in the first part of this study the GP is uniformly regarded as having the most power (of a patient / client, counsellor and GP). In the ‘God in White’ subject position the GP is characterized as being a source of respected knowledge whose

words carry great weight. The image of the ‘white coat’ invokes the idea that they “have all the answers” (A: 2/141-2) and implies great power associated with knowledge (in line with Foucault’s (1973, 1982) conclusions). This discourse was originally described by participant A in relation to how some patients see their doctors; however its discursive characteristics are also relevant in relationship to the heteronomous counsellor (indeed all of the participants drew explicitly on their own experience as patients in their interviews).

The researcher draws a parallel between the ‘God in White’, the version of the “Expert” doctor discussed in chapter two (Moore et al, 2005) and the notion of ‘Aesculapian Authority’ (Paterson (1957) where emphasis is placed on the doctor’s education and technical competence as well as more traditional paternalistic characteristics and charisma.

In fact the ‘God in White’ subject position attracts many of the negative aspects of power/knowledge (Foucault, 1982) including patient’s fearing how the doctor will use their power (see table 1) and the consequent need to keep ‘dark secrets’ from them, preferring instead to entrust these to a therapist. Alongside this fear there is also a clear discourse of the patient’s (and counsellor’s) *desire* for the doctor’s attention (again see table 1). GPs are felt to both gain and lose through this discourse – on the one hand it accrues status and respect, but on the other “there are also different kinds of doctors” (A:2/148) who will not wish to be seen in this way.

Discourses	Ref Int/Line	Discourse Summary Table 1 – Participant A Discursive constructions of the balance of power in the doctor/patient relationship	Sub-Theme	Who gains or loses?
The doctor as the god in white	1/527-8	Where the doctor says "try it out, it's a good thing" [they do] and because it's the doctor "ok, fine, yeah"	Desire for/submission to Drs power	The surgery is reinforced by positive views of powerful doctors
	2/93-4	[Sometimes] it's wonderful the doctor knows it all, they can [.] completely give over responsibility		
	2/97	Others say "the doctor thought it was a good idea so I went along with it because the doctor knows best"		
	2/141-2	For some, I think the dr is the god in white and has all the answers and they go there for support and guidance		
	1/473-77	Clients possibly don't feel they have a choice to really come, if the doctor in the white coat suggests it's a good idea	Experience powerlessness	
Patients sometimes fear doctor's power	1/18 -20	it takes some time to build up the trust that what we discuss in the counselling session will not be fed back to the GP [.] particularly the GP sees the whole family, so if there is an issue [.] any dark secrets, they don't want the doctor to find out.	Keeping secrets from drs	Doctors and patients lose as it reinforces the idea there is something to be afraid of. Counsellors gain as they can be the patients' secret keeper
	1/31-34	she was terrified of being judged [.] and she was terrified for not getting the same care possibly from her GP if he'd found out [.]		
	1/222-24			
	1/341	the GP is the one that holds the power,	Passive resistance by patients	
	1/212-4	R: clients [.] potentially having secrets from GPs: I Yes, yes, definitely,		
	1/511-3	they dish out a lot of prescriptions which will never be picked up, or perhaps picked up but never taken		
Patients want more attention from doctors than they have time to give	1/850-1	Some [patients] want the attention, and others want just to be in and out	Desire for doctor's attention	Doctors lose; if they do give time they get repeat visits and more dependent patients, if they don't, they risk being seen as technical. Counsellors gain as it justifies the value of listening.
	1/863-4	So there is definitely one where all the attention seekers go to and just hope he has lots of time <laugh>		
	2/168-9	All they want is strokes, attention, they don't want to explore, to move on, all they want is the dr says "oh, poor you"		
	2/209-10	It is positive attention, rather than perhaps the partner who is volatile, the dr will understand, the dr will not act out,		
	2/149-151	There are the drs who listen for a minute & then write out the prescription [.] and the others [.] listen to what the problem *really* is & engage with the client		
	2/223-6	The ones who spend more time listening that have those repetitive clients [.] if the dr takes out lots of time for one client the other one is waiting		
	2/231-3	puts the dr in quite a vulnerable position because lots of clients might become dependent on him so he might feel quite responsible [.] more responsible than the others who remain detached from them		

The researcher will now consider how participants framed their talk of patients' reactions to this kind of doctor and how that experience might impact subsequent relationships inside the surgery.

4.2.3 The heteronomous patient / client – the 'dutiful schoolboy'

Cast in relation to the powerful 'God in white' patients sometimes "don't feel they have a choice" (A: 1/474-77) to do whatever the doctor is recommending they do. Here then is one way in which a discourse suggests that a GP/patient relationship may impact therapy provided in the same surgery. According to this discourse, patients sometimes simply comply with their GP's recommendations. The patient is described as being able to be "sent" for counselling without having any clear idea of what they're being "sent" for (A:1/405-7), and also can be "sent" home by the counsellor (A:1/447-9) with the counsellor being cast as another authority figure (e.g. "the dutiful schoolboy being sent to the headmistress" (A:1/467-8)). This is reminiscent of Houses' discussion of the reluctant client who can "easily draw counsellors into unconsciously acting out from their own internal 'rescuer' or 'persecutor'" (House, 1995:90).

This patient is someone who is "done unto" (B:1/878) and who subjects themselves to a variety of medical procedures (which would appear to support the conclusions of Aubrey et al (1997) regarding therapists' perceptions of client motivations for therapy mentioned in chapter two.)

Patients can and do sometimes reject doctor's advice but in this subject position it will be in a passive way, by not turning up for appointments or not taking prescription drugs, for example, (A:1/510). Clients are described by one participant as sometimes worried, on entering the counselling relationship, that the counsellor will treat confidentiality in the same was as their GP and of the possible involvement of wider

social agencies without their consent – there is the sense that the patient is powerless in the face of the doctor, and some clients take time to trust that the counsellor does not hold similar power (see table 1).

The researcher will now move on to describe an alternative subject position for the GP – that of 'The Family Doctor' - which encompasses much of the same power and respect as the 'God in White' but overall is a more benign figure. Where the 'God in White's patient as a counselling client takes time to trust that the counsellor will not tell their secrets to their doctor (A:1/18), the Family Doctor's more autonomous patient has mainly come to counselling *because* it was their doctor who suggested it.

4.3 'The Family Doctor' and his patient

This subject position emerged most clearly from the transcripts of participant D. The 'family doctor' discourse encompasses the idea of the 'cradle to grave' GP of the early NHS who has built up relationships with entire families over many years, who will see a patient in a holistic way and be sensitive to wider issues beyond the biomedical. "He'd known them all for years, he knew people's parents, he knew their brothers and sisters you know there was that real history as well and that counted for a lot" (Appendix F, Table 2: D: 1/104-6).

The subject position of the patient of the family doctor is closer to that of an autonomous patient / client which as a discourse was present in a muted way throughout the transcripts. Rather than doing what the doctor says because of the perceived *power* of his position, the family doctor's patient implicitly *trusts* the doctor to not only have his best interests at heart but to know him and his circumstances in sufficient depth to make any recommendations worthwhile following. The family doctor will also have spent time discussing the available options with him. The family doctor discourse appears to blend the communication style of the mutuality model

advocated by Roter and Hall (2006) discussed in chapter two with either the old fashioned paternalism of Shorter's (1991) traditional model or Paterson's (1957) notion of Aesculapian authority (which blends sapiential, moral and charismatic authority).

In this discourse, therefore, the likelihood of the patient's being referred for, taking up and engaging with therapy are all *dependent* on the quality of the relationship between the family doctor and their patient. This is confirmed for participant D through discursive observations that referrals by locums for therapy are rarely successful (Appendix F, Table 2). This somewhat paternalistic discourse benefits those GPs who place importance on maintaining relationships in the face of the "reforms that have swept through the NHS [that] have meant that that's no longer possible" (D:1/174-7). Interestingly the participant saw this discourse as able to upset patients in as much as "to have the relationship spoken about and thought about in this way almost gives the relationship more reality somehow, I dunno - it may be a controversial thing" (D:2/199-200). It seemed uncomfortable to position the patient as party to a relationship based on unspoken or even unconscious forces.

It is important to note that the participant also spoke of possible exceptions to this discourse in recognising that when a patient who was new to the area or had little or no contact with the GP was in crisis they may well present to a GP and successfully connect into therapy.

The final set of discourses that comprise the research findings is that of the 'unofficial' discourses.

4.4 The 'Unofficial' Discourses: the 'imperfect GP' & the 'stubborn counsellor'

The researcher decided to group these discourses under a heading of 'unofficial' discourses to reflect some of the participant's discomfort (resistance) in describing

experiences which either did not reflect well on GPs (the 'Imperfect GP') or pointed to an on-going area of conflict in key subject relationships (the 'stubborn counsellor').

4.4.1 The 'Imperfect GP'

All the participants spoke of experiences where GPs had fallen short of the role expected of them in ways which had directly impacted their role as surgery counsellor. Two of the participants expressed discomfort in criticising GPs, but still had clear opinions they wished to express.

Parkers' discourse analytic method required the researcher to analyse for resistance (see section 3.4.3) and to highlight areas of contradiction (where subjects or objects are talked about in conflicting ways) and so the researcher explicitly raised these tensions for discussion in second interviews. Participant D (2/315-6) concluded that for some GPs, "in terms of counselling work and emotional language and emotional sensitivity, some people's strengths lie elsewhere I would say". In speaking in this way the participant is working hard to preserve the subject position of the 'heteronomous counsellor' in relation to the 'God in White' whilst also clearly saying something contradictory.

The 'imperfect GP' (D:2/346) emerges as a subject position in which the GP can be very technically competent but lack emotional intelligence and sensitivity, who is usually under great pressure in terms of both responsibility and time availability ('the busy GP'), but who is a fallible human being. When a GP refused to fulfil their perceived role to discuss a need to pass a client back, one participant said "I was absolutely livid because I thought, you don't care about these patients" (C: 1/106-7).

Individual GPs can be seen as victims of the system (B: 1/802) whether they try to listen and give time (A: 2/231-2) or not.

This discourse can also be seen to reflect the GP who is described as simply not knowing a lot about counselling and so sometimes doesn't know how to best use the service: "some of the GPs at least think anti-depressants is the cure to anything" (A: 1/348), "with the different approaches, I don't think they are very clued up" (A: 1/384-5), "they sometimes don't know what they're doing [.] sometimes I have the feeling that if a doctor doesn't know what else to do with a patient, they send them to counselling" (A:2/585-7).

When the notion of how GPs might react to the discourse of the 'imperfect GP' was discussed during the second interview, one participant was very clear that: "I think if we started talking about the imperfect GP & that really they're just fallible human beings like the rest of us [.] I don't think they'd be very happy [.] I don't even think some areas of medicine would even tolerate or allow the debate to happen at all [.] they're a very powerful, very powerful body (D:2/431-442). The 'unofficial' discourse of the 'imperfect GP' sits uncomfortably alongside the 'official' subject position of the 'God in White' who will not permit criticism.

In summary, the participants 'unofficially' discursively constructed the 'imperfect GP' as often not understanding the range of different types of counselling available, capable of being emotionally insensitive, sometimes treating counselling as being interchangeable with medication and therefore not being in the strongest position to educate their patients about what counselling might offer them.

All of these features were perceived to have an impact on therapy delivered in a GP surgery in terms of which patients ended up (i) being referred for it, (ii) deciding to try it or (iii) even discussing their distress with their GP in the first place. Clearly, it should be understood that all the participants knew a range of GPs with a range of strengths and weaknesses - the subject positions discussed here comprised the dominant discourses from the transcripts.

Finally for part one of the study, the researcher will consider the findings in terms of how participants talked of their response to the 'Imperfect GP'.

4.4.2 The 'stubborn counsellor'

This subject position arises explicitly in one participant's account (A: 2/644) in direct response to the frustrations experienced by the 'heteronomous counsellor' meeting the 'imperfect GP' (where they hoped to be dealing with either the 'God in White' or the 'Family Doctor').

The 'stubborn counsellor' persists in the attempt to deliver a valuable service to their clients in spite of the myriad ways in which GPs can misunderstand what they do. The counsellor continues to offer relational depth when GPs treat it like "a few doses of CBT and you'll be fine [.] they haven't really got a clue how deep it is" (A: 2/631-5).

Doctors were perceived to lose from talking of the 'stubborn counsellor', because it casts them in an unflattering light, but that counsellors win – this discourse justifies counsellors acts of resistance and characterises them as working thanklessly for the benefit of their clients. As Leonard (1997:47) points out, for Foucault "…power is not exercised without resistance, without insubordinacy and obstinacy, and we may see this resistance as an indicator that the subject, is, in part, self-constituted, able under certain material and historical circumstances to act as a moral agent."

Other participants spoke sometimes literally in hushed voices of stories they had heard where the system had failed patients / clients; "it just seemed like she was kind of slipping through everything, all the net, I felt frustrated" (C: 1/364-5), but had no way of making sense of these stories, simply experiencing them as anomalies. This seems to point as Leonard (1997:48) suggests to the idea that "structural contradictions and their attendant struggles enter the consciousness of the subordinate subject as a *disturbance* which points to the gap between dominant

discourses and the actual material experiences and practices of everyday life". Further, that the lack of an available alternative discursive subject position constrained "what can be said, done and felt by individuals" (Willig, 2008:127).

In overall summary of part one, the research findings are that the therapists interviewed talked of a variety of ways in which psychotherapy provided in a GP surgery may be affected by the relationship a patient has with their GP. These range from potentially detrimental impacts such as clients not being referred for counselling at all, sometimes feeling "sent" if they are and being slow to trust the confidentiality of the counselling relationship, through to more positive impacts such as the GP using the strength of that relationship to appropriately persuade someone of its potential benefits. The implications of the findings surrounding the idea of how far the medical model is 'infectious' will be discussed in more depth in chapter five.

The researcher will now describe the three sets of discourses which emerged from the second part of the study which saw participant therapists respond to the question "*How, if at all, does medical model thinking influence or enter your work in private practice?"*

4.5 Part two: the discursive construction of private practice in psychotherapy

In contrast with the discursive construction of primary care counselling, that of private practice was less substantial. Taking a critical realist view that it is social structures and practices that give rise to discourses as "the manifestation of structural relationships" (Burman & Parker, 1993:160) this is perhaps unsurprising given its more disparate nature. It is in fact the very lack of such social structure which makes up one the main strands of its discursive construction which combines a sense of isolation "I think psychologically the isolation can feel brutal occasionally, it's alleviated by the odd conference and supervisions, but nine and a half years into the

work um it's pretty lonely stuff it's just you and your books" (F: 2/1212-5) with the realisation that sometimes clients need more than one person: "so you do you do have a feeling that there are certain situations which you can't operate - you're one person and sometimes people need a team" (E: 1/751-4). This sense of some clients needing more was picked up by two other participants "when you're working privately especially you don't […] necessarily have the resources of a team around you" (H: 1/284-6), and "she started to collapse and at that point I said look I don't have the resources for you" (F: 1/227-8). It was also recognised that the support of a team or a social institution can help a therapist be heard: "I think if I had an individual sitting here without any other party, any other team […] it would be much more difficult, I imagine, for me to get support, get input, […] be listened to" (H: 2/61-3). The associated subjective construction of the 'therapist without a voice' is described in more detail shortly.

The other main strand of the discursive construction of private practice concerned money – this was in terms of both the perceived power and rights the commercial transaction confers upon clients and the need for therapists to earn a living. In terms of the former one participant was clear that "[…] fundamentally they're coming in and parting with their money um and that means that they have an expectation of something" (F: 1/994-6) and when explaining why he chooses to use some medical model language even though it no longer chimes with his own way of working "there's a commercial transaction going on - in that commercial transaction they need some signalling that their vocabulary is recognised" (F: 2/26-8).

The need to earn money was recognised by all the participants and there was an acknowledgement that occasionally meant that they had to decide what they were prepared to do to earn that money: "it's kind of a tussle with (…) going with one's own kind of ethical sense and wanting to earn some money in a realistic way, and I do like

to earn some money" (G: 1/241-3). (This theme will be returned to in considering a subject discourse concerning the need for pragmatism and collaboration when working with representatives of the medical establishment). One participant added that "they're paying me and they can choose when to go so they have power over my living" (E: 2/844-5) – for another the issue of earning one's living was a real concern: "this is literally bread and butter, hard core evolution Darwinian primordial soup stuff you know it's like how do I make it from month financially without going into arrears […]" (F: 2/1068-70).

Finally in terms of the discursive construction of private practice there were hints at the freedom that working in this setting can bring; one participant noted that seeing a private osteopath led her to see that "you could have personal autonomy and authority outside the health service" (G: 1/369-70) and another commented that "if you look at someone like myself working in the independent sector using the DSM IV, I can appropriate it for totally different agendas […]" (F: 2/184-6), but these were hints rather than a strong discourse and this will be discussed further in chapter five.

The researcher will now go on to describe two dominant discourses which emerged in relation to the medical model, named the 'Paradox of Power' (E: 2/214) and the 'Empire of the Medical Model' (F: 2/430). These will each be followed by descriptions of the key relational subject positions discursively constructed in association with them; the 'Doctor/analyst' and the 'Collaborative Therapist' in respect of the first; the 'All-Powerful Psychiatrist', the 'Therapist without a Voice' and the 'Modern Day Therapist who Refuses to Die' in respect of the second.

Within each of the discourses of the medical model about to be discussed, there were a number of objects (the DSM IV, medical language, medication, the NHS - including hospitals, clinics and GP surgeries), and subjects (GPs, psychiatrists (including doctors who are also analysts), therapists, patients and clients) common to

both - but what emerged in the analysis was a distinction based on the discursive emphasis placed on *power* and how participants talked of their relationship to it.

4.6 The Medical Model as the 'Paradox of Power'

Whilst the cultural dominance of the medical model was acknowledged by all the participants in some form or another; "the medical model is culturally imposed" (E: 1/61), "the medical model in vocabulary and discourse is ubiquitous and it pervades the mental health field" (F: 1/43-4), and "the medical model can't have not influenced me" (G: 1/50-1) the discourse of the 'Paradox of Power' (E: 2/214) was one in which the medical model was constructed as being simultaneously anxiety provoking and containing for patients/clients (perhaps echoing the discourse of the GP as the 'God in White' who is both feared and desired, from part one of this study). This discourse was particularly prevalent in the interviews for participant E - as suggested by the approach to discourse analysis being used, the researcher raised an apparent contradiction of ideas (multi-voicedness) from the first interview, in the second. This centred on the idea that on the one hand "people essentially don't feel safe with the medical model" (E: 1/455) and yet first, in respect of using the term 'consulting room' in their private practice "it is the medical model – I may have borrowed the word – 'consult' has an aura of confidentiality about it that what takes place in a consulting room doesn't leave it" (E: 1/1007-11) together with the idea that taking a patient's GP details somehow reassures them by linking the therapists work with that of the GP (E: 1/1100). What emerged was the idea that whilst patients fear a potentially judgemental response from a doctor and that "they're afraid that they'll be medicalised" (E: 1/443-5) there is simultaneously something 'holding' about some of the practices that go with the medical model.

Whereas in chapter two the definitions of the medical model encompass the relationship between a doctor and a patient, for this participant a distinction emerged

in the discourse between the two; it's "not always the medical model sometimes it's a transference from the relationship between doctor and patient into the therapeutic setting, it's not always the medical model" (E: 2/174-6). This distinction began to make sense as the interview proceeded and, as a Jungian, this participant drew heavily on the discourse of the 'Doctor/Analyst' (which the researcher will shortly move on to describe as a sort of hybrid between a doctor and a therapist subject position). In discussing the relationship between the object positions of Jungian thinking and that of the medical model it was suggested that Jungian thinking *integrates* the medical model and goes beyond it to a deeper level (E: 2/1018-24), working on many occasions via a doctor/patient style relationship - so what appeared to the researcher during the two interviews as a continual blurring of the lines between these two objects was probably a reflection of the integration of these discourses. It, therefore, made perfect sense to this participant that they could 'borrow' what they regarded as positive terminology and practices from the doctor's way of working *without* necessarily adopting any negative connotations of the medical model.

4.6.1. The 'Doctor/analyst'

This subject position was constructed as "a man who trains as a doctor and then trains as an analyst and then that power relationship passes to the psychotherapeutic but it doesn't take the medical model with it" (E: 2/193-5) and that "there are many psychiatrists who are Jungian analysts - it's very common" (E: 2/1145-6). Jungian doctor/analysts were positioned differently to those from a more classically Freudian position who were constructed as embodying something more authoritarian - "automatically there's an authoritarian line in Freud, now because I'm not involved in the Freudian scene that may have evolved so we have to bear in mind that I'm looking at it historically" (E: 2/772-4).

For the researcher, this construction of a Jungian doctor/analyst perhaps echoes the idea of the early involvement of doctors in asylums where they were involved not for their medical knowledge but "as a wise man" (Foucault, 1967:257). However, it is clear for this participant that an analyst does not *need* to be a doctor to work successfully with patients, and that in their discursive construction of Jungian practice there is no sense of conflict or contradiction between the medical model and the practice of therapy – initially it can be used to reassure a patient or be explicitly drawn upon to work with a particular issue ("it's important to study psychiatry, it does teach you a lot" (E: 1/468-9), but usually the latter leaves the former behind and journeys to deeper realms.

In terms of who benefits or loses from this discourse, participant E suggested that alongside Jungian analysts, doctors in general would benefit because the model of Jungian therapy integrates that of the medical model and "no one likes to be ignored in their work" (E: 2/1144).

4.6.2 The 'Collaborative Therapist'

This discourse emerged in relation to participant G who constructed a distinction between the medical model and the notion of *health,* seeing the latter as a much broader concept than just the knowledge and practices of the medical model: "health and care to me are words that sit with what I do […] and because therefore the person I'm seeing is the patient, the person who is suffering, I don't have a problem with that" (G: 2/36-8). They discursively constructed the role of the therapist as being one of "mind body spirit facilitation" although this was recognised as being "something which would frighten the life out of healthcare providers" as being too "new age" (G: 2/73-5). This reflected a deep pragmatism which emerged in the discourse of the 'Collaborative Therapist' who recognised that "you have to hold that on one hand and know what you think and believe whilst having to on a kind of

realistic in-the-world kind of way have to conform to some of this stuff because otherwise nothing's going to happen" (G: 1/261-4).

Whilst there was recognition that some groups of therapists struggled with the idea of engaging with doctors "there were some counsellors there who had been trained in a psychodynamic way […] who could not contemplate speaking to a doctor about a patient" (G: 1/304-7), for this participant there was no sense of such a struggle. In discussing power relationships with both doctors and patients, a key aspect of this discourse was in fact constructed as being to "behave like a human being and treat other people similarly" (G: 1/638-9), invoking the idea of a fundamental equality between people that transcends social role – "we all go in a box at the end as people" (G: 1/737).

4.7 The 'Empire of the Medical Model'

In contrast to the first discourse of the medical model described above, this second discourse, the 'Empire of the Medical Model', was most notable for participant F who characterised the overarching system which embodies the model as an "aggressive, frankly fascist hierarchical political attempt to destroy the very things therapy stands for namely agency amongst a whole bunch of other things" (F: 1/722-6) which has 'colonised' the field of mental health. The Empire is described as being made up of several facets; the hegemony of the medical profession and of medical language (which "infests and invades clinical practice" (F: 1/45-6)) and an overarching ideology which is seen as a "a systematic ideology that is driving people into a preconceived idea of normality – […] which reinforces a consumerist capitalist society" (F: 1/769-72). For this participant there was little differentiation between the medical model and politics - "I can't now distinguish psychiatry from politics – there is no distinction in my mind, they are agents of the state […] and they enforce the legal and political dictates of the state" (F: 1/900-2). In terms of who gains or loses from this discourse, they felt

that “the pharmaceutical industry would be hugely threatened because if you stop dispensing medication you're talking about billions and billions of pounds” (F: 2/436-41) and that more broadly the ‘Empire’ performs the function of keeping the population in check – so pointing this discourse out and talking about it would be threatening to society as a whole (F: 2/494-508).

For participant H there was perhaps an echo of this idea in that there was a clear sense that those working within the medical model system are charged with more of a responsibility to act “for the greater good” than therapists (H: 2/411) but that this can sometimes translate into actions which are not necessarily in the best interests of individual clients or patients: “it’s too easy for them to just come in and go right ok I know I've got it sorted what needs, I'm doing it for the best and so this is what I'm going to do, without maybe really stepping back and saying what's really going on here?” (H: 2/548-51). In both of the discourses of these participants there is a sense that the therapist and the client or patient’s interests are subject to the will of the doctor or psychiatrist. This discourse in some senses mirrors the idea which Siegler and Osmond (1974:89) discussed in chapter two of *public* medicine, in which “the clinical model can be suddenly superseded by the public health model with its heavy legal sanctions and its lack of concern for the individual patient”. This discourse is closely linked with the discourse of the ‘All-powerful Psychiatrist’ which the researcher will now move on to explore.

4.7.1 The ‘All-Powerful Psychiatrist’

Common to all participants to a greater or lesser extent was the discourse of the ‘all-powerful psychiatrist’. Asked to rank the key subjects of their interviews (psychiatrists, GPs, therapists, clients and patients) psychiatrists were universally listed as the most powerful, often with reference being made to their legal powers to section patients or determine state benefit availability. Whilst one participant saw the

role of the psychiatrist as more therapeutic via the subject position of the 'Doctor/Analyst', for the remaining three the psychiatrists' primary role was constructed as being to "to diagnose and medicate and medicate and medicate" (H: 1/765); "psychiatrists dispense and are legally allowed to dispense" (F: 1/261).

The discursive construction of how a psychiatrists power might be used or abused ranged considerably; at one extreme, participant F's experience was that "the violence and the aggression that they show towards vulnerable […] patients, for them, is beyond belief" (F: 1/262-3), leading him to state that; "the mental health of psychiatrists is under serious concern and needs to be professionally assessed" (F: 1/299-301). Other participant's views were less forceful, "the psychiatrist […] has the most power […], they have the most influence pure and simple,[…] in telling you who you are - you are, you have, you is" (H: 1/804-11). Both of these participants also commented at length about their experiences of, as therapists, being either ignored or treated hostilely by psychiatrists. The researcher therefore suggests that a partner subject position to the 'All-powerful Psychiatrist' is the 'Heteronomous Therapist', or the 'Therapist without a Voice'. Unlike the 'Heteronomous Counsellor' who emerged in part one of this study, the 'Heteronomous Therapist' is not reassured by or pleased to be subject to the power of the doctor or the medical system but deeply frustrated by it as we shall now move on to explore.

4.7.2 The 'Therapist without a Voice'

This discourse emerged strongly in the analysis of two participant's transcripts. Whilst three of the participants characterised their work as therapists as sitting outside the medical model one still felt able to be heard when needed (via 'the Collaborative therapist' subject position). The discursive construction of the therapist's position for the remaining two participants was remarkably different.

For participant H (see Discourse Summary Table 2) an ambiguity arose in the first interview surrounding the question of whether a therapist is qualified to comment or have their opinion listened to by the medical profession in general and psychiatrists in particular – “I never put over that I'm making a stand in terms of the diagnosis because I'm not qualified to” (H: 1/46-8), “I'm not qualified” (H: 1/260), “I'm not qualified to comment” (H: 1/176) and yet simultaneously feeling that they had something important to contribute “inside I'm going 'this isn't what it's about - this is not what it's about'” (H: 1/183). This ‘multi-voicedness’ (Parker, 2005) was explored in the second interview and what emerged was that they felt “[…] generally pessimistic that a gestalt psychotherapist which for some people is way over the fringe anyway probably wouldn't get a look in without any medical background” (H: 2/87-90) and that “without any previous psychology degree or nursing qualification I think the exclusion would come and they'd go 'well who is this person'” (H: 2/92-4). They went on to name this discourse as the ‘therapist not having a voice’ (H: 2/208).

Participant F discursively constructed a greater experience of outright hostility from doctors generally but particularly psychiatrists – in response to the researcher clarifying that “your experience has very much been one of them exercising their power against you?” they responded “Yes, yes in a deliberately premeditated, humiliating, derogatory manner which has no interest in the client” (F: 1/359-62). A client of theirs had requested to see them in hospital and “the consultant was outraged that somebody else was coming into his ward” (F: 1/343-4). He experienced psychiatrists as deliberately undermining his work with his clients “[…] he said ‘well I don’t think he will have helped you a great deal’ […]” (F: 1/210-1). The participant when on to describe their supervisor’s advice on how to respond to such situations as being “don’t destroy your career so early on, don’t take on these big fights’” (F: 1/1192-3) and that what the participant took from this was that “what she saying to me was ‘you’re nobody’ – you’re nothing – these guys will wipe out your ability to

practice “(F: 1/1195-6). As a result of these experiences the participant characterised psychiatrists as setting “[…] themselves up in conflict with me - I'm not interested in conflict with them, I'm very happy to meet them and discuss and negotiate” (F: 2/607-9).

4.7.3 The ‘Modern Day Therapist Who Refuses to Die’

The final discourse for the second study is again one which relates to that of the ‘All-powerful Psychiatrist’ and the ‘Therapist without a Voice’ and which seems, at least superficially, to have something in common with the ‘Stubborn Counsellor’ constructed by participants in the first part of the study – that of the ‘Modern Day Therapist Who Refuses to Die’. This discourse was named by participant F (F: 2/1055) who recycled a song title (‘the Modern Day Composer Refuses to Die’) in the service of our second interview. In analysing the interview transcripts for evidence of resistance as required by the method, this discourse sees the construction of the therapist who refuses to be cowed by the power of the psychiatrist, who struggles on with their independent practice – “this is about survival, about food on the table it's about electricity bills, well it has been for me anyway right - can you pay for your supervision, can you pay for your books” (F: 2/1056-8). In this discourse the therapist is pushed into a position of subversion – in response to a psychiatrist not wanting the therapist to work with his patient on the ward, they took their sessions outside in the

Discourses	Ref Int/Line	Discourse Summary Table 2 - Participant H Discursive constructions of the therapist	Sub-Theme	Who gains or loses?
Therapist without a voice	1/432-4	[R] does therapy ever sit inside the medical model [I] Well my therapy sits outside of it that's for sure	Therapist sits outside the medical model	
	1/46-8	[…] you know I'm not qualified - I never put over that I'm making a stand in terms of the diagnosis because I'm not qualified to […]	Therapist is not qualified to be heard by those in the medical model	Loses: Therapists
	1/53-4	medical profession and thinking you know 'is this fair on this woman' um, but have to bow to,		
	1/201-3	what can you do? You know we've got to take care of the other students […] but who am I to say?		
	1/258-60	and I'm not qualified and not trained psychotherapy is not for somebody who's psychotic […]		
	1/175-183	[…] so now she's having treatment, […] but I'm not qualified to comment but what I'm hearing is […] that she's making comments about wanting to kill somebody […] and I've heard all this sort of stuff before and it's just the outrage and its about the self really but immediately 'oh we can't send you back to university because you're going to go and attack 'someone' and inside I'm going 'this isn't what it's about - this is not what it's about'		
	2/87-90	so there's that aspect, then in being heard by "the official guy or woman" I think I am generally pessimistic that a gestalt psychotherapist which for some people is way over the fringe anyway probably wouldn't get a look in without any medical background	Psychotherapist with no medical background can't be heard	Gain: Those who get some kudos from resolving or fixing people
	2/92-4	without any previous psychology degree or nursing qualification I think the exclusion would come and they'd go 'well who is this person'		
	2/105-7	but when you put it at a distance and either say show me your bits of paper, or what are your qualifications that's when I feel I would not be heard or wanting to be heard		
	2/137-9	[R] so what qualification would enable you to be heard by the medical profession? My immediate answer is a nursing qualification	MM qualifications help you be heard	Gain: Those working inside the medical model
	2/141-147	[…] the route is what they want, usually would be somebody who has trained as a nurse and […]is supported within the medical world and they have more chance of being listened to		
	2/148-50	[R] so there's something in here about the medical profession simply not hearing anyone who isn't one of their own ? [I] I think so - yeah -		
	2/77-9	[R] that's an individual issue for you about being heard? that's my own stuff - but by definition I'm going to carry that into my world […]	Individual issue re voice not being heard is seen as a wider issue	
	2/208	there's definitely something this thing about having a voice		
	2/210	and it's strange that what I've said is what I've also said about myself		
	2/212	having a voice and then talking about having a voice		

hospital grounds “so I remember sitting in the snow with him (laughs)” (F: 1/371-2). It is suggested, however, that this isn’t a position the therapist willingly takes up: “most therapists are not sitting there thinking ‘I want to subvert the fucking capitalist system! I’m so bored I’ve got nothing else to do with my life! I know I’ll go off and subvert that through therapy!”” (F: 1/831-4) - it is a position taken up in direct response to the subject position of the ‘All-powerful psychiatrist’.

A similar discourse also emerged in participant H’s interviews who said that “psychotherapy approaches are a little bit subversive to society - to empower individuals and let them have a voice” (H: 2/182-4) and connected this to a need to champion the cause of their clients in the face of the powerful other who might be misunderstanding or mishearing what is being said – “it’s that crusade against being misunderstood, misinterpreted” (H: 2/346-7). Discursively the therapist is challenged at some point as having to answer the question “do you take your stand for society or do you take your stand for the individual?” (H: 2 /413-4). Therapy is potentially seen as “the word revolutionary is coming into my mind at the moment, anarchist if you read stuff behind gestalt therapy in particular […] the founders were anarchistical if that's the word, anarchical” (H: 2/173-6).

In terms of who gains or loses from this discourse, participant F was clear that “the therapy institution itself is undermined because what I'm really saying here is that we don't know how to support each other” (F: 2/1107-8), that each therapist is left to struggle on their own against the power of the dominant discourses emanating from the institutions and practices of the NHS. Participant H suggested that “well probably every patient is undermined” (H: 2/469) in that they are talked of as *needing* therapists to stand alongside them in the face of the powerful Other.

In overall summary for the second part of this study, the medical model is discursively constructed as having an influence on therapists in private practice primarily through the power relationships experienced with clients' doctors (both GPs and psychiatrists). These relationships range from the benign and collaborative to the downright hostile and aggressive, with each type of relationship inspiring a corresponding subject position for the therapist. The researcher will discuss the implications of the findings of both parts of the study in chapter five.

Chapter 5: Discussion and Conclusion

This chapter will cover four areas; first the researcher discusses the research findings in greater depth in relation to both the literature presented in chapter two and some additional literature which has presented itself as relevant since the completion of the analysis of findings; second, the researcher reflects on the wording of the questions used in each part of the study and what this might have set up; third the researcher offers a critique of the research method based partly on relevant literature but also on the experience of conducting this study; finally, the researcher concludes by considering what has been learned as a consequence of this research (including impacts on practice) and makes recommendations for possible avenues for future research.

5.1 Discussion of findings

Links between the findings and the literature reviewed in chapter two can be drawn on a number of different levels. As required by the research method used, some parallels have already been drawn at an individual discourse (or micro) level as part of the presentation of findings in chapter four (examples being of the 'God in White' and the 'Family Doctor' and the various models of doctor / patient interaction described by Moore et al (2005), Shorter (1991), Roter & Hall (2006) and Paterson (1957)). This discussion will attempt to locate the research findings in the context of the existing literature at a more macro level. Before starting this the researcher wishes to acknowledge that as with any piece of qualitative, small scale research, the findings cannot be generalised from – this discussion therefore is predicated on the assumption that findings are local and relative to these participants at this particular point in time.

It is also important to briefly highlight an issue associated with a Foucauldian approach to discourse analysis which is that he was more interested in the "'upward

reach' of discourse" (Hook 2005:44) into "large knowledge structures" rather than down into the "more micro-political contents" (the social rather than the 'psycho'). This leads to the requirement in Parker's method that "discourse analysis…treats the meaning of terms as deriving from the way they are articulated into chains of meaning that are independent of the speakers" (Parker, 2005:100) rather than becoming an attempt to discover "what people really think" whereby the researcher reduces "the things that are said to what the speakers really mean and worse, into speculation about what psychological processes or personality characteristics might explain why they said what they said" (Parker, 2008:101). In the attempt to remain true to the method chosen the researcher has therefore ensured that chapter four includes discussion of the discourses, or "chains of meaning", which emerged from the research only at a 'social' level. In this discussion of findings, however, the researcher now includes material that might be argued to stem from a 'psycho' rather than 'social' level of explanation. The issue of the balance between psycho-social explanations will be explored in detail in terms of a theoretical critique of method in the second part of this chapter.

As we have seen from chapter four, the main findings from the first part of the research study were that participants discursively constructed the GP/patient relationship as having several important impacts on counselling subsequently delivered in a primary care setting. These range from potentially detrimental impacts such as clients not being referred for counselling at all, sometimes feeling "sent" if they are and being slow to trust the confidentiality of the counselling relationship, through to more positive impacts such as the GP using the strength of that relationship to appropriately persuade someone of its potential benefits. How do these findings fit with the literature reviewed in chapter two?

The first set of links to the literature concerns the role of the GP. The relevant discourses that emerged from the research are those of the 'God in White, the 'Family Doctor' and the 'Imperfect GP'. Common to these discourses is the sense of great authority that the role of GP carries for good or ill, and this links strongly for the researcher to the notion of 'Aesculapian authority' which emerged as a key concept from the literature reviewed in chapter two. As will be remembered this is seen by Siegler & Osmond, (1974:93-9) to have three components; sapiential authority which "means the right to be heard by reason of knowledge or expertness"; moral authority, which is understood as "the right to control and direct by reason of the rightness and goodness according to the ethos of the enterprise"; and "charismatic authority, the right to control and direct by reason of God-given grace…". The discourses mentioned above could be seen to link to combinations of these types of authority, through them being exercised either successfully or unsuccessfully.

In addition to the role of 'Aesculapian authority', the literature on the GP/patient relationship also included research about the perceived time pressures on GPs and patients' conflicting need for time to work up to talking about difficult matters (Helman, 1994; Shorter, 1991; Roter & Hall, 2006) – issues which also appeared in these discourses. The researcher was also struck by the parallels between what Roter & Hall (2006:5) had to say about how patients may defend themselves from the reduction in emphasis placed on communication and attention-giving in the medical interview by "recourse to idealization or denigration of the physician" with the finding that in the discourses of the 'heteronomous counsellor' and the 'Imperfect GP' counsellors both wanted to believe in the infallibility of the GP - "I thought because the doctor referred him to me, I thought it will all be ok" (A: 1/78-9) – and to criticise them – ""they sometimes don't know what they're doing [.] sometimes I have the feeling that if a doctor doesn't know what else to do with a patient, they send them to counselling" (A:2/585-7). Whilst this is coming from counsellors rather than patients,

this finding could be seen to confirm what the literature is saying in this regard. Overall the discourses found concerning GPs were all recognisable to some extent from the literature reviewed on the medical model in medicine and the nature of the GP/patient relationship.

The findings from part one also seem to echo the findings of Cocksedge and May (2006:133-135) who, as discussed in chapter two, researched the "role of general practitioners in the referral process" to counselling in primary care, in as much as the reasons given for referral of patients for counselling seemed to reflect the range of assumptions made by participants (from the positive desire for patient well-being through to the desire to offload someone).

Perhaps most significantly the researcher noted that in part one of the study whilst the question specifically focused on an exploration of the possible impacts of the GP/patient relationship on therapy conducted in a GP surgery, only one of the participants interpreted these impacts as having anything to do with the medical model and therefore as potentially encroaching on their own 'non-medical' approach to therapy. This was intriguing for the researcher, as part of the recruitment process had involved all the participants declaring that their theoretical orientation was one which ***does not*** embrace the medical model / metaphor for psychotherapy. The researcher therefore reflected further on how far a medical model approach to therapy was evident in other aspects of the research findings.

All the participants understandably located GP counselling in the context of the overall NHS system, but only one questioned whether this was necessarily the right place for it; she explained that she had decided to go along with "the context in which it happens [.] in order for me to benefit, because it is a mutual benefit between me and the patients / clients as well" (B:2/427-9). In addition, three of the four used a lot of medical discourse language despite all of them experiencing some degree of

difficulty in explaining what they meant by terms like “mental health problem” (“oof [.] that would be a good essay question that” (D: 1 /280)).

As a consequence, the researcher wonders whether that with the exception of the one participant who had recognised that as a mental health nurse “I think I have integrated the medical model into my work over time” (D: 2/637-8), that prior to the research interviews the participants in part one had simply not thought much about the contradictions between the language they were using, the beliefs they seem to be engaging in and their model of counselling. Some of the participants were explicit about the fact the research was making them not only think about things in different ways but to act differently. The researcher sees a strong connection between this finding and the literature discussed in chapter two about the nature of medical models and how hard they have become to see (Boyle 2006; Elkins 2009; Wampold et al 2001).

In terms of the findings from part two, these were summarised in chapter four as being that the medical model is discursively constructed as having an influence on therapists in private practice primarily through the power relationships experienced with clients’ doctors (both GPs and psychiatrists). These relationships range from the benign and collaborative to the downright hostile and aggressive, with each type of relationship inspiring a corresponding subject position for the therapist. There are several important links to be made, therefore, between the literature reviewed on the historical development of the role of psychiatrists in dealing with human distress and participants’ discursive perceptions of them. The relevant discourses are the ‘All-Powerful Psychiatrist’, the ‘Empire of the Medical Model’ and the ‘Therapist without a Voice’. Whilst these discourses are all from the findings of the second part of the research study there were also some relevant statements from participants in part one. All participants perceived the psychiatrist to be the most powerful of all the

subjects under discussion and this power was explicitly linked to both the situational authority of being an NHS consultant and to their legal power to constrain a patient's freedom through sectioning. For the researcher this links clearly to the Foucauldian literature concerning the power of the medical establishment, which "subjugates. It forges persons as "docile bodies""(White and Epston, 1990:20). As participant F put it, the medical model is an "aggressive, frankly fascist hierarchical political attempt to destroy the very things therapy stands for namely agency amongst a whole bunch of other things" (F: 1/722-6) linking also to the postmodern idea discussed in chapter two that medical knowledge can be seen as "a belief system shaped through social and political relations" (Lupton, 1987:99). The link to Foucault continues within the discourses of resistance – 'the Stubborn Counsellor' and the 'Modern Day Therapist who Refuses to Die', for "Foucault himself was careful to emphasise frequently that where there is power there are always resistances, for power inevitably creates and works through resistance" (Lupton, 1987:102).

The other key aspect of the role of the psychiatrist that emerged from the findings was their perceived pre-occupation with administering drugs: "drugs - drugs, drugs, drugs - that's what it's all about juggle the drugs" (C:1/189-91); "medicate and medicate and medicate" (H: 1/765). The repetition felt necessary by both of these participants serves to underline the strength of this perception which seems to link to the role of the biological psychiatrist discussed by Shorter (1997:325) in chapter two: "In two hundred years' time, psychiatrists had progressed from being the healers of the therapeutic asylum to serving as gatekeepers for Prozac".

One apparent contradiction that emerged with the literature was the assertion by one participant that for them the doctor/patient relationship was not part of the medical model and that its therapeutic value could be transferred into psychotherapy without necessarily bringing the medical model with it (via the discourse of the 'Doctor /

Analyst'). As described in chapter two, Kihlstrom (2002:281) argues that the medical model is in fact ""centered on particular rules regulating two primary social roles: the doctor and the patient", however, it is possible that a version of the relationship based on different rules may have been being suggested by the participant. If the 'Doctor/Analyst' does not engage in diagnosis or any attempt to absolve the patient from blame (required parts of the role of the doctor according to Kihlstrom (2002)) but uses the therapeutically 'holding' frame of the consulting room, might this constitute an alternative? The participant was aware that such a frame might be simultaneously anxiety provoking, indicating that the 'Doctor / Analyst' is in no way able to control which aspects of the medical model are invoked. The question might be whether the perceived benefits of invoking "the beneficial psychological influence of the authority of the physician" (Abma, 2004:101), outweigh the disadvantages of a model which casts the patient as 'subject to' the power of the doctor (with for example threatened loss of confidentiality).

In chapter two the researcher reviewed literature which considers the use of the medical metaphor in psychotherapy and several alternatives to it, including the so called 'common factors' model which according to Sparks et al (2008:457) includes the notion of "a healing setting" (also regarded as essential in the 'contextual' model (Wampold, 2001)). The researcher wonders whether borrowing cues from the culturally dominant setting of the medical interview (such as calling clients 'patients', describing the therapy room as a 'consulting room', taking GP details and relevant medical information as part of a history taking) might be seen as an attempt to create such a setting. Three of the eight participants clearly saw their practice as lying outside the medical model, however, and made no reference to their use of any language or practices that might be considered as being borrowed from it. From one of these participants, in fact, there was an echo of an idea mentioned in chapter two regarding the role of the doctor in the asylum – "It is not as a scientist that *homo*

medicus has authority in the asylum, but as a wise man" (Foucault, 1967:257) when they remarked in relation to their role as a supervisor "it's possible to be a kind of wise-ish old bird without really taking a position of power" (G: 1/743). These participants seemed to see their practice far more in terms of dialogue and such ideas will be returned to in a consideration of implications for practice.

The researcher will now consider the findings from the research as a whole and how these link to the literature both included in chapter two and that which has presented itself as relevant since conducting the empirical research.

The first of these concerns the theme of ambivalence in feelings towards doctors which emerged strongly from both parts of the study. From part one the discourse of the 'God in White' (A:2/141) includes clear statements about the patient's fear and desire for the GP's attention (these feelings also appear in the discourses of the 'heteronomous counsellor' and 'the imperfect GP'). In part two, in the discourse of the 'Paradox of Power' (E:2/214) medical model practices are conceived by participant E as being simultaneously anxiety provoking and holding (as described above). Perhaps, in Foucault's (1982) terms, these discourses reflect the positive and negative connotations of the power/knowledge embodied in the role of the doctor.

Another aspect of the ambivalence of feelings towards doctors is reflected in how constrained participants in part one felt in talking of experiences which might be seen as critical of either individual GPs or the system in which they worked. As counsellors constructed themselves as feeling both protected and frustrated by the power of the GP it would seem logical to conclude that this gives rise to both the desire and reluctance to criticise them. Foster & Murphy (2004), in their consideration of counsellors motivations for working in the NHS, also raise the issue that such motivation may effect a therapists' behaviour within the service (for example "a tendency to conform rather than challenge") and suggest that "it is important…to

keep in mind our possible motives, both personal and historical, for entering the profession in this particular context, if we are to understand something of the dynamics of which we then find ourselves a part" (Foster and Murphy, 2004:296). The tension in this relationship seems to be important particularly in terms of how able counsellors feel to influence the provision of local services relevant to their clients.

The second overall finding is the difference in response between each set of participants to their discursive construction of their position in being 'subject to' the authority of the doctor – where the counsellors in the GP surgery constructed themselves as being largely relieved to be able to pass responsibility back to a doctor, participants in part two of the study talked more of their frustration at the lack of opportunity to collaborate with doctors, for their opinions to be not only sought, but heard and acted upon – "I'm happy to talk - I'll meet them at the ideological level ok but they cannot do that, they are incapacitated they are actually crippled and disabled and unable to make that kind of dialogue happen" (F: 2/607-98). Staying within the method used, the researcher can reflect upon who is supported or undermined by these constructions – the social power of the doctor is largely maintained by the constructions from the majority of part one participants whereas it is more frequently challenged by those from part two. The researcher is aware of several potential explanations of this finding, however, which arguably sit at the level of individual psychology and so exemplify what using Parker's approach to discourse analysis excludes.

The first is that based on analysis of the motives counsellors might have had over the years to work within the NHS which reveals for some the desire to be "an insider rather than an outsider" (Foster and Murphy, 2004:296), it is possible that there is an inherent bias in the motivation of primary care counsellors towards a preference for

not being ‘clinically responsible’. By extrapolation it could be argued that those choosing private practice wish to work independently (to be on ‘the outside’) and to therefore take an appropriate level of ‘clinical responsibility’ - these explanations sit at least partly at the level of individual psychology. Second, the basic fact that all of the participants in part one were either trainee counsellors - or had been until very recently - could suggest that maybe this is an issue of professional confidence in terms of career maturity. Again this is saying something about individual psychology.

Third, and finally, the researcher has subsequently found references to many of the frustrated participants’ difficulties in the literature concerning ‘split’ treatment. This is “a clinical term in general psychiatry that customarily refers to the prescription of psychoactive medication by a psychiatrist while the remainder of the therapy is conducted by another psychotherapist, usually a nonphysician” (Myer & Simon, 1999:327). As Pilowsky and Bellinson (1995:26) elaborate, “Split treatment usually begins when a psychotherapist refers a patient to a psychiatrist. The actual relationship and fantasies of the psychiatrist-psychotherapist dyad may facilitate or hinder their collaborative treatment. The therapists may overtly or covertly devalue each other's contributions thus, creating a painful experience for many patients”. Whilst such a model appears to have become increasingly common in the United States (Imhof, Altman & Katz, 1998) through the impact of their managed care system, it is unclear as to how far it has reached the UK as a formal practice (rather than one which simply happens ad hoc as in the experience of participants H and F, with an attendant lack of formal care and attention being paid to the complex dynamics of the relationships involved.) Again, this is an explanation which draws on theories such as the psychoanalytic concepts of transference and countertransference (Imhof, Altman & Katz, 1998) and so sits at a ‘psycho’ rather than ‘social’ level.

In general the findings from part two were far less homogenous than those from part one. As briefly mention in chapter four, the researcher wonders how far this might be considered a vindication of the version of critical realism espoused by Parker (2008:2) in asserting that “subjectivity is discursively reproduced within present social arrangements” or as Willig (2008:113) puts it “Foucauldian Discourse Analysis asks questions about the relationship between discourse and how people think or feel (subjectivity), what they may do (practices) and the material conditions within which such experiences may take place” – as the ‘social arrangements’ and ‘material conditions’ surrounding private practice are not only far less structured than those of institutions like the NHS, but also not so imbued with medical model thinking, this could perhaps explain the greater variety of subject positions emerging in the discourse of the participants in part two and the comparative lack of presence of the medical model discourse. As Fairclough (1992:26) puts it “the language that people have access to depends upon their position in the social system”. Whilst there are those that argue there is an increasing prevalence of the use of medical model discourse in wider society (Philo, 1994; Scott, 1994), one possible conclusion of this study is that for these participants, regardless of counselling modality, a medical setting for counselling insidiously conveyed a medical model discourse more strongly than wider society did as the ‘setting’ of private practice.

5.2 How were the findings influenced by the wording of the questions?

This brings the researcher to some thoughts on how the findings were influenced by the wording of the questions used. As Willig (2008:21) comments, “It could be argued that one of the outcomes of qualitative research should be an understanding of what would have been an appropriate research question to ask in the first place!” The researcher has recognised at least three problems with the questions asked in this study.

First, in considering the opening question for part one - *"is the medical model infectious*?" - continuing the analogy for the moment, the researcher now wonders how many therapists are actually 'infection free' when they take up their positions in GP surgeries in the first place and in the second, are aware that there might be an 'infection' to guard against. As Sanders (2005:26) puts it the medical model has become "not only the dominant ideology of distress, but the *only* ideology of distress. It has become a 'given' to be taken for granted – that which we think *from* rather than we are able to think *about*. The thought that human distress might not be an 'illness' is not merely radical, it is inconceivable".

So the question for part one assumed that the participants would *know* about the medical model in both medicine and psychotherapy. The researcher made the mistake of assuming this at least partly because participants had selected themselves into the research on the basis that they rejected the medical model but as the researcher had not defined this clearly it left room for confusion. As a result, rather than participants talking of how *they* perceived the medical model might be 'infectious' it put the researcher in the position of having to highlight discourses which implied the possible presence of 'infection' and reflecting these back to the participant. This gave rise to some interesting moments in the second interviews.

The second issue with the question for part one is that the researcher is now aware that the analogy of 'infection', whilst being mildly intellectually ironic, sets up a judgemental stance towards what could be regarded simply as a different, albeit dominant, therapeutic approach – this made the researcher's job harder when it came to talking about therapy based on the medical model in terms of recognising difference and honouring it, rather than automatically taking a pejorative stance.

As a result of this experience with part one the researcher decided to make a discussion of the role of the medical model more explicit in part two and as discussed

in chapter three, operationalized the research question as “how, if at all, does medical model thinking influence or enter your work in private practice”. The researcher also included a discussion of what might be meant by the medical model in the recruitment of participants. Despite arguably being open to medical model influences from a wider variety of sources than therapists working in GP surgeries (for example from private medical insurers, employee assistance programmes, industry specific advertising directories etc.) the findings from part two of this study have shown that those working in private practice discursively constructed themselves as being almost solely influenced by the medical model through their encounters with GPs and psychiatrists (whether directly or indirectly via their mutual clients). In terms of other evidence of the medical model, in the findings for part two there was far less use of language that one might associate with this model and three of the four participants were clear that their work sits firmly outside such an approach, with the fourth locating their work as ‘going deeper’ (E:2/1029) than it. In general whilst the medical model was more explicitly under discussion in part two it was in many ways less present – as already discussed its impacts were more directly located with very particular clients in particular exchanges with GPs or psychiatrists.

Third, in terms of problems with the questions asked and probably most fundamentally, both of the operational questions asked assume that it might be *possible* for participants to discern what the impacts of the GP / patient relationship or the medical model might be, as though it were a variable that could be isolated from all the other myriad influences. Given the discussion in chapter three of the nature of modernist approaches to research, the researcher now recognises the difficulties of this idea in the context of a piece of research with any kind of pretensions towards working within a postmodern epistemology. It demonstrates how hard it is, amongst other things, to escape a cause and effect view of the world and perhaps research questions worded to make a more general enquiry into

participants' experience of medical model discourse might have taken the research a step closer to this goal. It can be argued, however, that this issue is inherent in the underlying ontological position of critical realism which posits that there are material structures 'out there' which "generate phenomena, versions of which we then construct through language" (Willig, 2008:130) arguably in a cause and effect relationship.

Having discussed some of the findings in more depth, located them in the literature and discussed the perceived impact of the wording of the research questions used, the researcher will now move on to a more detailed critique of the research method used.

5.3 Parker's Discourse Analysis – a critique

In their 1993 paper, Burman and Parker discuss thirty two different problems they saw with Discourse Analysis - given constraints of space here the researcher will discuss five issues which have had particular relevance for this piece of research.

As already mentioned, the first and most significant of these to the researcher as therapist, concerns the focus on the social level to the exclusion of the individual. As Willig (2008:123-4) puts it the "availability of subject positions in discourse cannot account for the emotional investments individuals make in particular discursive positions" – whilst discourses are involved in the construction of subjectivity, are they *enough?* As has already been discussed, in Parker's (2005:101) method the researcher is warned against speculating about individual participant's psychological processes and at times the researcher found this a struggle. Whilst some examples of this have already been included in the first part of this chapter, a further example clearly located at a personal level may help to illustrate the issue. It concerns the feelings that one participant expressed about a GP who had retired - the researcher realised that much as patients were described as desiring the attention of the

powerful doctor, so to did the participants (who as has already been mentioned are not only counsellors but also GP patients themselves): “Dr <A> would seek my advice and recommendations and I felt really quite valued by him, whereas since he's left I don't feel as valued” (D:1/706-7). As briefly discussed in chapter two, Stein (1985) has written about the role of transference and countertransference in doctor / patient relationships and had the method allowed it the researcher would have speculated about this in relation to this participant. Stein’s thoughts also seem relevant to the talk of the doctor as the God in White; “the *accusation* that physicians play God is an attribution to medicine of the *wish* to be cared for by a perfect undifferentiated father-mother” (original italics) (Stein, 1985:56).

The researcher returned to Foucault (1969) to try to make sense of this struggle. On the one hand, and as discussed in chapter one, he seems to state that the subject only appears through discourse, that it has no prediscursive existence (Bunton & Peterson, 1997). In reading ‘The Archaeology of Knowledge’ (1969), however, it seems clear that he suggested instead that there had been a historical (arguably Husserlian) tendency to ignore the role of discourse in constructing subjects in favour of assuming the existence of a ‘transcendental subject’ and that in looking for “a field of regularity for various positions of subjectivity……it must now be recognised that it is neither by recourse to a transcendental subject nor by recourse to a psychological subjectivity that the regulation of its enunciation should be defined” (Foucault, 1969:61). Importantly he went on to say that “The analysis of statements does not… replace a logical analysis of propositions, a grammatical analysis of sentences, *a psychological or contextual analysis of formulations*: it is another way of attacking verbal performances, of dissociating their complexity, of isolating the terms that are entangled in its web, and of locating the various regularities that they obey” (emphasis added) (Foucault, 1969:121). To the researcher therefore he appears to be saying that the emphasis should be more on subjectivity as a social and

discursive construction, more in line with Heidegger's (1927) 'dasein' ('being-in-the-world') which emphasises the power of culture and society, rather than Husserl's phenomenology in which the subject's mind is able to "'stretch forth into the world'" (Spinelli, 2005:15) through the process known as intentionality in order perceive phenomenal objects. Simply put, are we more 'subject to' than subject? He addresses a perceived resistance to this when he asks "What is that fear which makes you reply in terms of consciousness when someone talks to you about a practice, its conditions, its rules, and its historical transformation?" (Foucault, 1969:231) and acknowledges "how irritating it can be to treat discourses in terms not of the gentle, silent, intimate consciousness that is expressed in them, but of an obscure set of anonymous rules" (Foucault, 1969:231).

To some writers, and indeed to the researcher, however, it feels that discourse analysis can be in danger of tipping the balance too far the other way in favour of the social and so some discourse analysts such as Hollway & Jefferson (2000), advocate a psychosocial approach to discourse analysis "that applies psychoanalytic interpretative strategies in order to 'thicken' discursive reading" (Willig (2008:124). According to Hollway and Jefferson (2000:13) "whatever it is that social factors explain, it falls far short of a complete explanation" and that "the premise of a socially constructed subject…makes it impossible to encapsulate fully the diversity of individual's lived experience". They therefore attempt to consider people's investments in particular discourses – "by investments, we mean someone's desires and anxieties, probably not conscious or intentional, which motivate the specific positions they take up and the selection of accounts through which they portray themselves" (Hollway & Jefferson, 2000:15). Whilst they use various concepts drawn from the work of Klein in exploring how to theorise the 'self' they maintain a dual focus on both the psyche and the social - "we need to show how conflict, suffering and threats to self operate on the psyche in ways that affect people's positioning and

investment in certain discourses rather than others. This will help us understand the workings of the psyche and the social simultaneously" (Hollway & Jefferson, 2000:19). Of particular interest to the researcher is their evocation of "the defended subject [which] shows how subjects invest in discourses when these offer positions which provide protection against anxiety and therefore supports to identity" (Hollway & Jefferson, 2000:23). Could this kind of reading have offered an explanation as to why participant D, missing the presence of the GP who valued his input, was invested so heavily in the discourse of the 'Family GP'? The researcher therefore wonders whether discourses are *only* socially determined, and that as Leonard (1997:33) hoped there might be "a more dialectical understanding of the relationship between individual and society". What might the implications of this be, however, for postmodernism? Does this essentially imply a return to modernist thinking, "with the productive subject as the centre"? (Loewenthal, 2003:373).

Burman and Parker (1993:158), remaining true to Foucault's intent (Hook 2005), acknowledge that they are ambivalent about the use of psychoanalytic concepts, seeing a problem with "discourse analysts pursuing their texts in a way that is suspicious of what is manifest, and looking to hidden meanings", whilst recognising that they accept that "semantic phenomena" can be "overdetermined" (i.e. have multiple causes.) As Yates & Hiles (2010:53) put it, "it would ill behoove anyone who takes these arguments seriously to reproduce the notion of the transcendent, ahistorical subject which was anathema to Foucault …There is thus a challenge to be faced in making subjectivity amenable to study in discourse analysis". They go on to suggest that Hook (2005) "hints at a balance to be struck in theorizing subjectivity without tipping over into resituating the singular subject as centre of meaning and interpretation" (Yates & Hiles, 2010:53). Hook (2005:28) himself is quite clear, however, in his belief that "genealogy and psychology are uneasy bedfellows; in fact, they combine like oil and water". He explains that "the effect of much of Foucault's

genealogical work… is exactly that of the destruction of the individual self-reflective, self-thematizing human subject**,** certainly inasmuch as the latter acts as a privileged vehicle of explanation" he posits as being central to psychology. The human subject is for psychology "the object of analysis it cannot dispense with if it is to maintain its viability as a discrete discipline of knowledge" (Hook, 2005:28). In espousing the use of a pure form of Foucauldian genealogy, which he describes as the study of "a potent combination…[of] reactivated historical contents alongside a set of dismissed, rejected knowledges", Hook (2005:5) continues to reject the idea of an active subject in saying that "rather than move ever further 'into' a discourse, towards a hidden interior, a supposed 'nucleus' of signification, one should examine its exteriority, look to those elements which give rise to and fix its limits; its external conditions of possibility" (Hook, 2005:10).

Perhaps rescuing the value of discourse analysis for psychological research and psychotherapeutic practice, Willig (2005:32) alternatively stresses the idea that "We can think of the human subject as being constituted by historically and culturally specific discourses and practices, and at the same time acknowledge that this subject experiences him / herself as thinking, as feeling, as embodied". She goes on to suggest that "a better understanding of how subjective experience is constituted through the ways in which we position ourselves within available discourses and practices over time (as Foucault puts it, '(. . .) the history of how an individual acts upon himself') may help us to think more creatively about how to facilitate alternative subjectivities for ourselves and *those we work with*" (emphasis added) (Willig, 2005:33).

As equally as a participant's subjectivity should not be taken for granted, the same holds true for that of the researcher. Hook (2005:36) highlights the dangers of simply restoring a central subject "in the figure of the interpreter" and suggests that

“discourse analysis, in the models provided by both Parker (1992) and Potter & Wetherall (1987) cannot rescue itself” from this claim. Burman and Parker (1993:156) do note that discourses don’t just emerge from the text and highlight the importance of being aware that “analysts are not only readers but also producers of discourse. They are implicated in the production of the forms of knowledge they describe”. The researcher’s viewpoint is necessarily embedded in the research findings and in this case the most major influence on that viewpoint has been the training programme for which the research is being conducted. Having completed a programme of study focused on an “exploration of major phenomenological currents in European… therapeutic thinking, as manifest, in particular in humanism, psychoanalysis and post-modernism” (Loewenthal and Snell, 2008:43) the researcher was required to complete a piece of research that reflected this programme of reading.

How has this therefore positioned the research and the researcher before a question was even devised? Just as discourses don’t just emerge from the text, research questions don’t just emerge from the researcher – “where the researcher and her/his organisation stops and the researched starts is not clear” (Loewenthal, 2003:373) - there are academic and political influences at work and at times the researcher explicitly discussed these influences with the participants as co-researchers. For example the researcher’s programme of study both heavily influenced the researcher’s desire to use a qualitative research method which might be regarded as postmodern and introduced the researcher to Foucauldian discourse analysis (which whilst not a new method and growing in popularity (as already discussed in Chapter 3) is not perhaps as well-known and accepted as other methods such as Grounded Theory). Parker (2005:29) suggests that “reflexivity helps us question our experience, “asking how it might have come to be that I felt this or that about what happened”. That is, the self is not treated as the bedrock of experience but as something that is crystallized from historical and institutional structures. It is collective

matter". Considering both the psycho as well as the social, the researcher also agrees with Banister et al (1994:14) who discuss the importance of a "reflexive analysis which respects the different meanings brought to the research by researcher and volunteer" and treats them as "valued resources rather than factors that must be screened out".

This brings the researcher onto the second potential criticism of Parker's (2005:96) method; the use of the second interview. What does it try to achieve? Whilst it might appear as a modernist attempt at validation, to get closer to a participant's 'truth' as if that were a fixed thing, as described in chapter three Parker sees it as enabling participants to join in the process of naming and exploring discourses in terms of their impacts. So is it about validation and / or some process of co-creation of meaning?

In terms of the first of these, Hollway & Jefferson (2000:43) appear to agree - "the second interview would act as a check in various ways by allowing us to seek further evidence to test our emergent hunches and provisional hypotheses". However, despite Burman & Parker's (1993:156) belief that the second interview might ameliorate the "power of the analyst to impose meanings upon another's text" might it not also be seen as an opportunity for the researcher to enforce their views and create a dominant discourse within the interview process itself? This might be even more of an issue should the researcher take up Parker's (2005:96) option of using a 'reflecting team' which involves the researcher and a colleague discussing the discourses in front of the participant, thereby "making the discourses visible". The researcher did not use this option and this meant having to take a very active part in the second interview, explicitly acting as a co-constructor of meaning, in order to stay close to the interview plan (described in chapter three). At times this was frustrating for both parties as the researcher struggled to make the difference clear, for example, between thinking about the effects of *talking* in a particular way about

something (e.g. the doctor as the ‘God in White’), rather than the effects of the phenomena itself. Had the researcher used a reflecting team this problem may have been much reduced – maybe they would not have needed to make the method so visible, as it would have allowed the participant to simply comment on the implications the reflecting team would have generated. It is clearly possible, however, that using such a team may have generated as many problems as it solved.

Finally in terms of validation, Giorgi (2010:13-4) offers an alternative more modernist view in stating that “There is no reason to automatically assume that a layperson’s insight into a disciplinary meaning is equal to, or better than, that of a researcher who works within the discipline. It is obviously acceptable to give participants feedback concerning the study in which they participated, but not for purposes of validation”. He is therefore suggesting that validation is possible, just neither necessary nor desirable. Scheurich (1995:249) on the other hand represents a more postmodern view in suggesting that validation is simply not possible – “techniques like prolonged interaction or joint construction… will not lead to a more correct interpretation because …an indeterminate ambiguity, "a wild profusion," lies at the heart of the interview interaction”.

In terms of the second potential purpose of the second interview, a joint construction of meaning, Scheurich (1995:243) goes on to suggest that, “Interview interactions do not have some essential, teleological tendency toward an ideal of "joint construction of meaning," no matter how Rogerian the researcher-interviewer might be. Human interactions and meaning are…a shifting carnival of ambiguous complexity, a moving feast of differences interrupting differences.” Might the best that can be hoped for from such an interview, therefore, be an exploration of ambiguity and change? This is closer to the researcher’s own experience in which the second interviews served to demonstrate how discourses change and evolve over time – the participant who

could no longer recognise her words as a disempowered trainee (B:1/329-31) from the first interview because she had changed status to a qualified counsellor in the interim would seem to once again illustrate Parkers' (1998:2) stance of critical realism that "subjectivity is discursively reproduced within *present* social arrangements"(researcher's italics). The researcher is reluctant to completely abandon the claim to some limited co-creation of meaning with participants even if it has emerged simply through a reduction in ambiguity and misunderstanding – it is too important when the researcher is attempting to give a voice to those who might otherwise not be heard. In this respect a final perceived benefit of the second interview was that as Hollway & Jefferson (2000:43) found "It also gave interviewees a chance to reflect" - participants therefore had a chance to tell the researcher how the research had already resulted in perceived changed thinking or action.

Finally the researcher considers three potentially related criticisms of discourse analysis discussed by Burman and Parker (1993:156-160). The first is that from such a study one cannot make generalizations – "it is difficult to move from a specific text…to a wider context". The researcher with any belief in postmodernism (as discussed in chapters one, two and three) must accept that the findings are local and relative. This is connected to a second potential frustration, that there is little "opportunity for consideration of large-scale political consequences of the repertoires in the material being studied" even though the discourses discussed are positioned as emerging from the wider social structure. As White and Epston (1990:29) highlight however, "This is not a political activity that involves the proposal of an alternative ideology, but one that challenges the techniques that subjugate persons to a dominant ideology". Whilst this might be seen by some as a limitation, it is the fact that this research method is *designed* to expose such techniques and to highlight the operation of dominant discourses remains exactly why the researcher chose it for this study. The researcher must own, however, that this choice is at least partly rooted in

the researcher's own prior studies in sociology (which in the 1980's encompassed a lot of Marxist ideology) which left them with a tendency to look to social systems for explanations rather than to individuals. In training to become a psychotherapist, therefore, it has been necessary for the researcher to expand their conceptual model of the world (previously dominated by cultural and social influences) to one which places a greater emphasis on the role and dynamics of the individual psyche. It might be helpful for a reader to understand this, as, as a consequence, the researcher has tended to be drawn towards the political role of the dominant discourse of the biological approach to understanding human distress which, by de-emphasising the importance of meaning, denies an opportunity for alienation to be voiced within a capitalist society.

There will also undoubtedly be readers who will find some of the views expressed by the research participants' extreme (for example participants F & H and the discourse of the "Empire of the Medical Model"). Within that discourse, however, the researcher recognises the continued spirit of the anti-psychiatry movement. These participants are also in august company. Leader (2012:325) has recently discussed the dangers of where biological psychiatry can lead; in its attempts to identify "a healthy 'us' from an unhealthy 'them'" he recognises that "the rise of the biological approach has brought with it the spectre of the eugenics movement that had such devastating effects in the early twentieth-century and in the Nazi period" (Leader, 2012:325). As he goes on to note "Although we might like to think that such debates were suited to the climate of Nazi Germany, they were in fact rooted in British and American thought." Something appears to be being said about the potential de-humanising impact of exclusively biological approaches. Participant F also speculated about the mental health of some psychiatrists with whom they had come into contact (one in particular who had been "outraged" that a client had asked to see my participant as an in-patient on "his" ward (F:1/343-4)). Interestingly House (2003:48) summarises

that “Buck (1992), Knight (2001), and Lowson (1994) have respectively coined the terms “Pervasive Labelling Disorder”, “Psychiatric Delusional Disorder”, and “Professional Thought Disorder” to describe [these] alienating diagnostic procedures”. This latter (PTD) is described as follows; “The major characteristic is an assumption of intellectual or moral correctness or superiority frequently held in spite of the presence of evidence to the contrary” (Lowson, 1994:29). Whilst the views expressed by participants are not the same as the researchers’ own equally the researcher has no desire to distance themselves from those views either. They discursively construct psychiatrists and the mechanisms of the control of those deemed mentally ill in such a way which fits broadly with the researcher’s own views about how the world can be seen to work when looked at in terms of social systems.

Despite well-intentioned individuals within such systems, it is also the researcher’s experience that it has become the norm to prescribe a course of ‘drug’ therapy (whether anti-depressants or return-to-work focused psychological therapy) rather than to acknowledge that something might be existentially wrong in someone’s world, and engage in the difficult work of helping them understand what that might be and what they might choose to do about it, or even less attractive, to recognise the social component of what might be causing them distress and working to address that too. A biological approach can perhaps safely allow the cause of distress to be located in the individual whilst neatly absolving them from blame for it.

This brings the researcher to the third and final connected criticism, which Burman and Parker (1993:160) describe as “the perils of reductionism” and concerns how far individuals are seen as ‘subject to’ dominant discourses or invested with the power to resist; heteronomous or autonomous? According to Leonard (1997:17), “Foucault’s perspective on the constitution of the subject reveals to us that the identity of the individual is a site of domination, but also an actual or possible site of resistance, of

political struggle". This appears to be saying that whilst the individual is 'subject to' this is not the whole story, that at a local, individual level, resistance is not only possible but inevitable; quoting Foucault, Leonard (1997:47) reminds us that "where there is power there is resistance". According to Scheurich (1995:248), however, "to enclose social life within the dominance-resistance binary is but another prison house of language, meaning, and communication" – that for him this represents a reductionist approach. He proposes therefore that there should be an additional "open-ended space which I, with irony, call chaos… What I mean by "chaos/freedom" is everything that occurs that is neither dominance nor resistance; everything that escapes or exceeds this binary is chaos…and represents openness or freedom for the interviewer and interviewee".

Having reflected upon several key criticisms of the research method, the researcher will now consider what they have learned as a consequence of conducting this research and possible avenues for future research.

5.4 Conclusion

Foucauldian Discourse analysis "aims to produce knowledge about the discursive economy within which we find ourselves, how it got to be this way (historically) and what this means for us as human subjects" (Willig, 2008:125). The researcher's starting point had been a wondering about whether other therapists who *also rejected the medical model of psychotherapy* experienced the same issues of felt encroachment by medicine's own medical model on their work in both the GP surgery and in private practice. As Wampold (2001 : xii) suggests, "psychotherapy is a very personal and life changing experience, one that cannot be forced into a medical-like treatment without losing the essence of the endeavour". It is the risk of therapy slipping unrecognised into the medical model that this research intended to explore because the researcher has come to believe that there are important

consequences attached to how therapists perceive human distress. Whilst we can appreciate that “medical models of emotional distress are powerful for many reasons, including the fact that they borrow credibility from the prestigious languages of science and medicine and receive strong support from the pharmaceutical industry” (Boyle 2006:199), the researcher tends to agree with those such as Sander’s (2005:38) who, when giving his reasons for promoting the options of refusal and principled opposition to the medical model, stated that “the metaphor for distress that we as therapists carry with us into our work influences *every aspect* of our relationship with our clients. If we think sick we will see sick”.

Elkins (2009:76) suggests that as practitioners, “First, we must decide what our posture will be relative to the medical model. Making this decision is not easy.” In terms of impacts on practice, the researcher feels that this research serves as a vital reminder that the first requirement is, in fact, to remain *awake* to the idea that there is a choice to be made at all. In terms of resistance, therefore, one of the questions for this piece of research is how far is it possible for individual counsellors, working in a non-medical model way, to not only maintain that way of working potentially in the midst of a medical-model environment - to resist - but also to educate those around them about even the existence of their approach, and develop it further without it becoming, for those working in primary care, an employment threatening activity. There are those that believed this to be possible - House (2003:244-5) saw the GP setting as potentially one in which “postmodernist deconstructionist views can sit quite comfortably”, providing it is able to hold its own against the “continual threat from the forces of modernity”. The researcher wonders how far counselling can still be said to be holding its own in this way in light of the increasing insistence via the ‘Improving Access to Psychological Therapies’ (IAPT) programme on the use of only those therapies approved by the National Institute for Health and Clinical Excellence (NICE). As NICE gives primacy to those therapies able to provide research evidence

based on the use of Randomised Control Trials (RCTs), a research methodology predicated on the medical model (Guy et al, 2012) it is arguably unlikely that primary care counselling in non-medical model modalities will survive on any scale in the NHS for much longer.

There is still resistance going on – there are counsellors trying to find ways to get round the now mandatory requirement to record an 'indicative diagnosis' for example – but given the findings of this research, the researcher wonders how many more counsellors are simply uneasy about what is being asked of them without really being able to articulate why. Have our professional bodies done enough to try to co-ordinate resistance, to sound the alarm to alert us to the need for action, or were they equally asleep to the eventual consequences of NICE's approach to guideline development? Given such bodies represent those who do subscribe to at least a medical metaphor for psychotherapy as well as those that don't, how able were they ever going to be to respond coherently to this threat? In the words of one research participant "what I'm really saying here is that we don't know how to support each other […] I'm not getting any sense of people working together, I get a strong sense of people shooting each other down…you have to do it on your own at this stage in the life of the profession" (F:2/1112-8).

It can be argued, however, that whilst the findings of this research have been that the medical model was well-nigh invisible for the participants working in a medical setting, that the increasing roll out of IAPT and consequent squeezing out of traditional counselling services *has* served to re-awaken the profession to this battle. The fact that the United Kingdom Council for Psychotherapy (UKCP) launched a campaign looking into NICE's methodology whose "guideline production process uses an overly medicalised perspective on emotional distress and treats psychotherapy as if it were a drug for research purposes" (UKCP, 2011) serves to

illustrate this re-awakening. Despite this questioning, for the researcher, it has come too late. Whilst at the start of this research process it was their experience that there were still some pockets in which IAPT had been implemented in such a way as to not threaten either the delivery or ideology of non 'NICE approved' forms of therapy, by the end the grip had tightened to such an extent that the researcher chose to stop working in such a setting.

Beyond the important decision of selecting the setting for therapeutic practice, this research has also highlighted another related implication for practice – that of how far it might be possible to reclaim notions of 'health' and 'healing' from the dominant medical model discourse for use in connection with the practice of therapy. Whilst intellectually we may understand that these terms are of longer standing than concepts of western biological medicine, are they inextricably linked in our minds and those of our clients? What do we open the door to when we call ourselves 'health care providers'? (G: 1/196). If we are not concerned with health, however, what are we concerned with? Heaton (1998:41) contends that "medicine inserts itself within the process of nature in so far as it seeks to restore a disturbed process but in such a way that ideally the art disappears once health is restored" – can psychotherapy perhaps also be regarded in this light, as equal but different to medicine? If this might be possible, it would seem that therapy can ill afford to borrow the trappings of medicine - almost especially those which might help create the illusion of a 'safe' and familiar environment for a client – if it wants to distinguish itself as a separate dialogical practice.

The researcher had designed the original research question against the backdrop of wider debates then current in psychotherapy - about professionalization and the push, as discussed via NICE, for the generation of a preferably modernist evidence base for the efficacy of the different types of therapy – debates centred on some of

the key differences between modernism and postmodernism – about what constitutes knowledge and what is most likely to promote real ethical responsibility to the 'Other' of the client in the context of a post-existential view of practice (as touched on in chapter one). The actual findings have changed the researcher's pre-existing beliefs about the power of the medical model and its impacts on psychotherapy. On the one hand its invisibility and taken-for-granted nature to the participants working within a primary care setting was more severe than expected. On the other, it was discursively constructed as having less of a wide-ranging impact on the participants in private practice. Rather than seeking to ruthlessly identify the medical model in client work in order to automatically reject it, what the results have done is to enable the researcher to in some sense be more objective about it. Through understanding it in more depth and talking to people about it at length, the researcher is now perhaps able to consider the implications of medical model thinking in all its guises in their client work alongside other theoretical models within a broadly post-existential approach. It nevertheless remains important to remember that "there is one model which is more equal than the others; this is the medical model" (Siegler & Osmond, 1974:19).

One final implication perhaps concerns the finding that it has been through their relationships with individual GPs and psychiatrists that participants' have constructed the biggest impact of medical model discourse on their practice and perhaps more importantly on their clients. Rather than becoming overly embroiled in assigning personal psychological meanings when such difficulties arise perhaps a greater focus should be brought to bear on social structures which might better support clients working with both medical and psychotherapeutic professionals, (known in the literature as split treatment), not with the intent of simply understanding the issue but to bring about change – as Foucault (1977a: 154) put in his maxim 'knowledge is not made for understanding; it is made for cutting'.(Hook, 2005:8)

This has lead the researcher to consider areas of future research and what has emerged for the researcher as the most critical element of the medical model and its potential influence on the experience of therapy delivered is that of power. A research question more focused directly on power could be more openly inquisitive about the nature of power relations and practices in the therapy room and in the psychiatrists consulting room - how are they *talked* of? How are they *constructed?* What do therapists do or not do in relation to it, what struggles do they experience? How do clients experience it? Is it possible to ask? The researcher is particularly interested in the structural power inherent in the positions of GP and psychiatrist and how it might be possible for them to work alongside psychotherapists in support of their mutual patient/clients in developing truly therapeutic relationships. This perhaps would fit with an exploration of the phenomena of split treatment in the UK across all psychotherapeutic settings, as a cursory search has revealed no such work to date.

Finally the researcher has wondered about the question of what 'capacity to take action' might have been generated for this study's participants as subjects. The findings have illustrated that for four of the eight participants their talk suggested that they have integrated the medical model into their way of thinking, with only one of these able to articulate how this fitted with the philosophy of their original training. Two of them, however, were quite explicit that participating in the research had made them think more deeply about the medical model and how it impacted their work; one commented that "in just doing this research I've been changed in the way I think about things" (B:2/88-89) and had tried to make a change in her work set up as a result. The other participant who talked about the impact of the research mentioned having opened discussions with GPs and colleague counsellors on how far the medical model is actually dominant.

The local discourses seen in this small scale study reflect the real struggles going on at the front line of therapeutic delivery and are inevitably small scale and personal but as such reflect the local discursive economy. As well as giving a voice to the imagined marginalized and beleaguered non-medical model practitioners in private practice, however, has this research also given voice to an even more marginalized group of therapists - those for whom these issues are not visible and of little apparent relevance? They continue their work, striving to offer something of real value to their clients despite the system in which they work, silently, stubbornly, offering relational depth as best they can.

It is possible that when this study is published to its small audience that it might again prompt therapist readers to think about where they stand on this issue and how that fits with their original training. The researcher appreciates that in terms of action research these are not large changes, but maybe small scale, local change is the only real change possible - as Parker (2005:123) says “all research is action that works for or against power”.