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**PSYCHOTHERAPY'S IMPACT ON SOCIETY**

**by**

**Peter Cobrin**

**B.A. University of Toronto, 1982**

**M.A. University of Windsor, 1990**

**A Dissertation  
Submitted to the Faculty of Graduate Studies  
through the Department of Psychology  
in Partial Fulfilment of the  
Requirements for the Degree  
of Doctor of Philosophy at the  
University of Windsor  
Windsor, Ontario, Canada  
1995**



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## ABSTRACT

Psychotherapy's impact on society is examined by comparing the relevant literature on the issue with themes generated from 24 semi-structured interviews with practising psychotherapists. The process of transforming the interview material into a hierarchical arrangement of themes is based on Rennie's (1992) version of Grounded theory. The study is also based on Lather's (1991) attempt at combining critical theory with social constructionist inquiry. Generally, the main purposes of this study are: 1) to better understand how psychotherapists make sense of their role in society; 2) to assist psychotherapists in thinking about these issues, and; 3) to incorporate the experiences of real life psychotherapists with the literature on the topic. There have been a number of criticisms of mainstream clinical psychology that point to its role in perpetuating the present societal power structures thereby acting as a barrier to the mental health of its clients as well as society at large. I will argue that clinicians should become more aware of the powerful effects of their work to better facilitate their clients' empowerment through emancipatory means. This entails helping clients choose their own course of action, based partly on an understanding of the societal causes of their powerlessness. According to the themes that emerged from the interviews, the most prevalent view is that therapy has an individualistic focus. This view stresses the importance and possibility of not imposing values on clients who are believed to be powerful themselves. Alternatively, a less widely held position is a critical reading of the social effects of therapy's almost exclusive focus on the individual. In order to combat these negative affects, this view is consistent with the belief that therapists should be more pro-active agents of social change. In addition to the role of contextual factors in the research process, some of the differences between the critical literature and the thematic presentation of participants' pronouncements might be due to the critical literature's adherence to a more socialistic perspective and to a mix of Foucauldian and Gramscian conceptions of power, compared to the participants'

adherence to a more liberal–humanist perspective and to more mainstream conceptions of power. A dialectical perspective that incorporates individual and societal considerations meets most of the concerns of the critical literature and of the participants. It ensures that clients are respected while at the same time promotes the well–being of society.

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# CHAPTER I

## INTRODUCTION

A number of allegations have been levelled against psychology for its role in actively supporting part of the status quo, thereby preventing social change. However, detailed arguments needed to support these accusations are lacking (Prilleltensky, 1994). To rectify this apparent discrepancy, I will offer in the first part of this research project my own systematic reading of how mainstream clinical psychology is implicated in perpetuating the structural conditions that act as a barrier to the mental health of its clients, of many other members of society, as well as society at large. I will argue that clinical psychology's complicity is largely unexamined, given the prevailing belief in the value-free metatheory of logical positivism. Previous attempts at incorporating critical social theory in clinical psychology are presented, and their level of success is discussed. In the second part of this research project, I will invite practising psychotherapists to participate in an exploration of these topics.

Prior to proceeding with a detailed analysis of these topics, I will first provide an overview of the area, as well as define some key terms.

### Overview

In North America, the last two decades have seen the moral foundations of previously revered institutions profoundly shaken. Media reports have helped uncover many cases of individual misconduct within the medical profession, politics, the police force, the religious clergy, etc.. The mental health profession has not been spared public scrutiny; within clinical psychology, the most startling exposure of moral ineptitude are the current rash of popular media accounts of therapists abusing their clients.<sup>1</sup>

Within psychology, it is expected that the members of the discipline's regulatory bodies will take concrete action against those offending clinicians who abuse their clients.<sup>2</sup> These

regulators are socialised to comprehend the gravity of individual unethical behaviour. Their training prepares them to be sensitive to serious individual wrongdoings, and their professional ethical code demands that they act on their sensitivity.

Far from denigrating the attempt to protect individual clients from potential therapist abuse, many commentators (including myself) fear that the profession is fooling itself in assuming that its ethical responsibilities are being fully met by taking action against individual therapists. This perspective maintains that a therapeutic profession that takes its responsibilities to individual clients seriously, but that mostly ignores its obligations to society, is seriously deficient. This claim rests on the assumption that the threat which the therapeutic enterprise may present to certain segments of society is as great as the dangers which individual therapists may pose to their individual clients.

That clinical psychology poses a threat to some groups in society (especially to minorities) is predicated on the contention that the present societal power structures contribute to the disempowerment of certain groups. Clinical psychology reinforces their disempowerment by unquestionably "taking the organization of industrial society for granted, as the unproblematical context of life" (Bellah, Madsen, Sullivan, Swidler & Tipton, 1985, p.47). By accepting the present power structures embodied by particular organizational principles, such as capitalism and consumerism, psychology not only supports, but gives these organizational principles a new justification and legitimacy (Danziger, 1990).

There are a number of ways in which clinical psychology as a social institution manifests its power in upholding these societal status quo mechanisms. For example, in therapeutic discourse and practice, therapists focus on individual factors (e.g., genetic or psychological constitution) when accounting for individual and/or social behaviour; they analyze social problems in terms of psychological maladjustment; they pretend that their theories are value neutral; and they have a propensity to portray values that benefit the

dominant segments of society as benefiting society as a whole (Prilleltensky, 1994). These actions may be portrayed as techniques of social control, that have the effect of supporting dominant (status quo) world views.

It is important to expand on the concept of power, given its centrality in the subsequent argument. Power is a ubiquitous phenomenon. Although it is not a tangible entity, the effects and experiences produced by the use of power are a constant transactional component of everyday social interaction. I will very briefly outline two approaches to conceptualising power: Foucault's relatively micro-level perspective as well as Gramsci's more macro-level theoretical treatment of power.

Foucault's position is that the power to affect society is not locatable in the traditional geographical sense, in that it does not emanate from a directly observable source. He suggests that "politics is not reducible to the practices of the State, for power does not arise in any central point" (Gubrium & Silverman, 1989, p.5). Instead, power is manifested through the agency of micro-social practices (Fraser, 1989; Sarup, 1989). Its applications are synonymous with all social interaction. In its capacity to affect all social practices, power is a necessary component of all action. In basing his discussion on certain historical exemplars of the exercise of power (e.g., psychiatry and psychology), Foucault seems to suggest that power is also related to the hierarchal structure in society. This postmodern conception of power differs from more traditional understandings, in that power is productive rather than prohibitive; capillary, in that it operates at the lowest extremities of the social body in everyday social practices; and it touches people's lives more fundamentally through their social practices than through their beliefs (see Fraser, 1989).

Though the analysis of other theorists have a somewhat different focus, their conclusions regarding the power of psychotherapeutic practices are similar. For example, from a more macro-level theoretical perspective, power still does not emanate from above, through

some sort of ruling class conspiracy. However, it is more identifiable, in that it propagates itself on an institutional level. The power of these institutions stems from their hegemonic position in society. Gramsci (see Hoare & Smith, 1971; Sullivan, 1984) is a leading proponent of this other view. For example,

For Gramsci, hegemony refers to a form of ideological control in which dominant social practices, beliefs, and values are reproduced and disseminated through a range of institutions such as schools, family, mass media, and so on. Hegemony assumes the existence of a totality that saturates the society to such an extent as even to constitute the limit of common sense for most people under its sway. (Sullivan, 1984, p.89)

Hegemony exists in four major ideological realms: economic, cultural, political and social. Psychology (which includes clinical psychology) is part of this last realm.

The following inquiry examines how the power of clinical psychology helps maintain part of the status quo.<sup>3</sup> This examination reveals more than just independent acts of uncaring behaviour; it points to deep-seated flaws within the therapeutic enterprise itself. This analysis, of the structural deficiencies in the therapeutic endeavour, as presently constituted, reveals the need for therapists to be more aware of their metatheoretical stances. In particular, they need to be more aware of the effects of their work on their clients and the more indirect, though potentially insidious and powerful effects that they also have on society at large. This reexamination hopefully will stimulate some psychologists to adopt a more pro-active stance, encouraging them to develop and reshape their role in, and their relationship with society at large.

It is suggested that clinicians more directly act as both individual and as societal change agents by facilitating their clients' empowerment through emancipatory means. Traditionally, emancipation refers to "the process of separation from constraining modes of thinking or acting that limit perception of and action toward realising alternative possibilities" (Thomas, 1993, p.4). Given this definition, many pragmatic acts can be labelled emancipatory. That is, emancipatory acts can range all the way from reformulating a statistical problem

permitting a solution to helping minorities in third world countries free themselves from oppression (see Rogers, 1990).

I move away from this highly formalistic definition and instead rely on Lather (1991), Minton (1993), Prilleltensky (1994), and the critical ethnographic tradition (see Thomas, 1993) in explaining empowerment and emancipation. These perspectives resist reducing the application of these terms to acts of individual self assertion, or to the experience of feeling powerful. Rather, their use of these terms includes facilitating the process of individuals choosing their own course of action, based partly on their analysis of the societal causes of their powerlessness. Such an analysis would include the recognition of the ideological underpinnings in society.

These approaches understand ideology critically, linking it to the process of maintaining domination. From this view, ideology describes particular shared sets of fundamental beliefs, attitudes and assumptions about the world, that is, those that restrict our perceptions and interpretations of discourse and action. Being "an allegedly disinterested knowledge which serves to conceal an interest under the guise of a rationalisation" (Ricouer 1981, p.80), ideology helps maintain particular societal interests.

Through an appreciation of the ideological underpinnings in society, empowered clients will learn to recognise the systemic oppressive forces affecting all of our lives. They will become cognisant of the fact that the present unequal distribution of the wealth and power in society severely restricts access to services, education and employment, all of which seriously affects psychological well being. Having this information is crucial, given the belief that knowledge is used to maintain oppressive relations. This belief is based on the Foucauldian notion that, "as brute force has decreased in its usefulness for managing people, knowledge that structures human experience has become more important" (Sampson, 1991, p. 294; also



see Kirby & McKenna, 1989). Having knowledge of these oppressive forces, clients will be able to critically explore the allocation of the wealth and power in society.<sup>4</sup>

Practising this genre of emancipatory therapy satisfies Prilleltensky's and Walsh-Bowers' (1992) demand that the psychological profession adopt a moral imperative. The moral imperative they espouse obliges psychologists to contribute, pro-actively, to the advancement of the 'good' society. They understand the three fundamental pillars of the 'good' society as being self-determination, distributive justice, and collaborative and democratic participation. Therapists who comply with this moral imperative contribute to this 'good' society by reflecting on the social consequences of their work, by respecting the capacity of their clients to select their own goals and to defend their own interests, and by pro-actively taking actions intended to foster the well-being of both their clients and the entire community.

This understanding of emancipatory therapy is also related to the notion of conscientization, which Prilleltensky (1990a) borrows from Freire (1971, 1975). Though not originally designed for describing therapy per se, it is appropriate to import this concept, as it describes a process whereby people become aware of the socioeconomic, political and cultural circumstances that help shape their lives, and therefore gain insight into how they can transform their social reality (also see Lather, 1991).

It is acknowledged that the above arguments are not original. Previous efforts have been made at examining the social implications of therapy, for example, the 'Radical Therapist' movement, community psychology, and feminist psychology (e.g., see Castel, Castel & Lovell, 1982; Sarason, 1981b). However, it is safe to assume that psychology at the service of the status quo represents a more pervasive phenomenon than the sporadic efforts to promote social change (Prilleltensky, 1994).

In the next section of this chapter, I will offer evidence from the literature to support the contention that few practitioners seriously question whether clinical psychology upholds the

status quo. Central to this argument is a discussion of how its logical positivist orientation helps account for this lack of deliberation. This analysis is somewhat congruous with the approach advocated by Lather (1986, 1990, 1991).

In the third section, some past examples of how marginalised groups within psychology have attempted to remedy this situation are discussed and critiqued. Some of these approaches are based on an alternative set of overarching guiding principles, that might be of use to clinical psychologists who are dedicated to practising emancipatory therapy, as described here.

In the second part of the research project, this theoretical model, relating clinical psychology to the social order, is more directly examined through local observation. That is, instead of relying on the existing literature, therapists are asked to discuss their own perceptions of psychotherapy's impact on society. In line with the call for greater self reflexivity within the profession, they are asked to consider the kinds of political ramifications that their work has, both on their clients and on the world at large. They are offered the opportunity to discuss their own detailed and nuanced perspectives on, and interpretations of, this issue.

As with most dissertations, some readers might interpret the first part of the research project (the literature review) as an up-to-date reading on a substantive topic. However, where my approach differs from traditional dissertations is that this reading is offered as one construction among many to be considered, rather than as the definitive privileged comment on the state of affairs. In fact, the design itself demands that this construction be modified, in light of the offered constructions presented in the second half of the research project. Guba and Lincoln (1989) declare that "it is a rare constructivist study report that begins with a review of the literature" (p.210). They say if a literature review is required by a journal editor or by a dissertation committee, then it "deserves to be treated no differently from information gleaned ... from local observations" (p.211).

In so far that my arguments are meant to persuade, no attempt is made to pretend neutrality. In the spirit of previous attempts at developing socially informed psychotherapeutic practices, the first part of this research project consciously privileges the marginalised view that therapists should take their social responsibilities more seriously. Being aware that this agenda has political overtones, and the conscious use of politically loaded language to further this agenda, are consistent with two of the major themes of this paper. These themes are: 1) the need for self reflexivity, and 2) the notion that everything, including the use of language, is political, and has moral implications.<sup>5</sup>

### Clinical Psychology and the Status Quo

In presenting my construction of how clinical psychology helps perpetuate part of the societal status quo, I will first consider the importance of this issue and its relationship to the power of psychologists in society. I then address the following topics: 1) the notion that clinical psychology's relationship with society is geared toward maintaining the status quo; 2) reasons why clinical psychology should take a self-reflexive stance; and 3) the general failure of clinical psychology to reflect on its place in society.

Psychotherapists (psychologists, psychiatrists, social workers, etc.) have a direct impact on a significant proportion of the North American population. In an American survey conducted in 1980, there were over 25 million office visits to psychiatrists, and over 26 million office visits to psychologists in that particular year alone (Taube, Burns & Kessler, 1984). In 1987, one American in three had been in psychotherapy, and 15 million Americans had made roughly 120 million visits to mental health professionals, nearly twice as many visits as to internists (Hunt, 1987).<sup>6</sup>

Psychotherapists are also instrumental in shaping the North American cultural landscape. Living in the 'psy' society, even if one has never set foot in the sanctum of

sanctums (the clinician's office), it is difficult not to be influenced by, and indeed depend on, the long arm of the mental health professions. These professionals are seen as society's official interpreters, as the experts who are assigned the task of alleviating pain and suffering. Psychoanalytically derived conceptions permeate North American religion, law, literature, and discourse, with such terms as repression, rationalisation, the unconscious, dysfunctional this, and dysfunctional that (Berger, 1965). Newspapers, magazines, popular television shows and movies are replete with quotes from Dr. Expert Clinical Psychologist. As two commentators have recently pointed out:

Newspapers describe the activities and opinions of psychologists on marriage, love, child rearing, and other aspects of day-to-day life.... To state it bluntly, psychologists have considerable power to influence the opinions and behaviour of the public. (Kipnis, 1987)

Only psychology, we are told, can divine our secret motivations and reveal the elusive "why" of the strange human animal. The rules of discovery require professional interpretation. Just as the clergy once mediated between man [sic] and his soul, so the psychiatric and psychological professional must now interpret the mind for man [sic]. (Gross, 1978, p.14)

Given the pervasiveness of their influence, therapists are not only in the position to wield considerable power; whether or not it is desired, their position entraps them into exercising their power. This notion is predicated on two core beliefs; that it is both generally, and also within the context of therapy, impossible to maintain value neutrality (Sullivan, 1984), and that the therapeutic institution exercises power.

Given the previous discussion, it might be expected that therapists exercise power, since power is an inevitable byproduct of all social interaction. For example, Frosh (1987) describes the conventional notion of a distanced stance by the 'all powerful' psychoanalyst:

The structure of the psychoanalytic situation is not simply one in which one person unavoidably has some power over another; everything that is done therein serves to increase that power. The analyst remains mysterious while the patient discloses the most intimate recesses of her/himself; the analyst is silent while the patient speaks; the patient is observed and the analyst invisible; and everything that the patient says is scrutinised for hidden meanings, so that even criticism of the analyst is interpreted as belonging elsewhere. The analyst can

never be confronted, s/he epitomises that subtle power that slips away, unspoken but dominant. (p.259)

Admittedly, psychotherapists differ, and probably very few of them perfectly resemble this exaggerated caricature. However, most therapists do remain somewhat mysterious, scrutinising their client's verbalizations much more than their own.

Power gets played out through the expression of values. Therapists' value systems play a crucial role in almost all aspects of therapy. For example, they are an important factor in the consideration of who is in need of treatment, that is, who is considered mentally sick or diseased. How to decide who gets labelled 'sick' is a very tricky question. Sedgwick (1982) claims that illnesses or diseases do not exist in nature. They are just value laden labels we voluntarily attach to naturally occurring circumstances that precipitate undesirable states of being. Without getting into the sticky issue of whether Sedgwick is correct in his assertion that all illnesses or diseases are socially constructed, the point is that values play a role in determining who is in need of treatment.

In therapy itself, therapists' values come into play through the Foucauldian concept of individualising visibility. Individualising visibility is similar to the popular concept of the client internalising the therapist's values. It involves the detailed observation of individuals, their habits and histories, with the goal of transforming them into facsimiles of their observers. In time, this observation is internalised to such a degree that, in effect, individuals are made to scrutinise their own thoughts and actions, admonishing themselves when they revert to their previous 'selves' (see Foucault, 1967; Frank, 1987; Fraser, 1989; Philip, 1985).

Values also play an important role in determining when to end treatment. Pallone (1986) remarks that Lewis Wolberg's authoritative, encyclopedic The technique of psychotherapy (1988) devotes only 16 of its 1,343 pages to the process of termination.

In his discussion of the criteria for termination of treatment, Wolberg sets it forth that termination is appropriate [with emphasis added] 'when the patient has

achieved optimal functioning within the limit of his [sic] financial circumstances'.  
(Pallone, 1986, p.54)

For responsible clinicians who refuse to follow this advice, it seems that they must rely on their own personal value system in determining when to end therapy.

The second suggestion made above is that the therapeutic institution exercises power. Accepting Foucault's proposition, that power is a property of all micro-social practices, it is a relatively small step to extend his argument, so that it includes the utilisation of power that has social effects. In the case of clinical psychology, the social power at its disposal is more penetrating than most other forms of social power. Clinical psychology's power is more acute because therapists can rely on their position in the structured hierarchy of society to "get hold of their objects at the deepest level –in their gestures, habits, bodies, and desires" (Fraser, 1989, p.24).

From the Gramscian perspective, that psychologists' power stems from their hegemonic position in society per se, Gannon (1982) suggests that therapists are viewed by individual clients and society at large as powerful professionals, embodying expert knowledge. Perhaps there are certain social obligations attached to the exercise of such knowledge, apart from those associated with the immediate relationship with their individual clients.

The argument has been made that no one is neutral, and given that we live in the 'psy' society, psychologists in general have tremendous influence. Therefore, serious implications inhere in the political stance of those therapists who believe that their ethical duty is to deal exclusively with their individual patient's discomfort, and who ignore social issues.

### Maintaining the Status Quo

What is now addressed are the means for which the power of psychology are employed. In particular, the suggestion is made that, instead of exercising its power to encourage social change, clinical psychology's reliance on psychologism helps perpetuate

certain aspects of the societal status quo (Barratt, 1984; Bellah et al., 1985; Danziger, 1990; Frosh, 1987; Gerber, 1990; Gill, 1978; Laing, 1967b; Rothaizer, 1979; Sarason, 1981b; Sedgwick, 1982; Sullivan, 1984).

Psychologism is clinical psychology's response to the age old debate concerning the relationship between the individual and society. Psychologism postulates 'Self' at the centre of the universe; it understands the ultimate source of behaviour to be within the individual. As Gross (1978) states: "The lure is irresistible. To egocentric modern man [sic], the prospect of Self instead of God seated at the centre of a world philosophical system is exquisitely attractive" (p.14).

There are a number of ways in which such an assumption of individualism within clinical psychology is associated with the maintenance of certain societal status quo mechanisms. For example, psychologism helps mask the social factors that impact on individual functioning by reflecting dominant world views, e.g., capitalism and consumerism, and by creating techniques of social control. In addition, there are two particular ways in which the above tasks are carried out: in the assessment enterprise, and in the use of so-called value-free scientific statements. These points are discussed in turn. However, I will first illustrate how social factors impact on one's interpretation of optimal individual functioning and how clinical psychology ignores these factors by relying on individualistically based theories.

#### Impact of Social Factors

Laing (1967a), in one of his less shocking pronouncements during the 1960s, suggests that mental disorder is an appropriate response to the normal alienation associated with capitalism. He says that the so-called abnormal response to the deprivations associated with capitalism and consumerism, of 'going mad' or 'being out of one's mind,' is preferable to the normal condition of alienation, given that 'normal' men have killed perhaps 100 million of their fellow normal men in the last fifty years. Jacoby (1975) presents a similar message. He argues

that, in this society, human relations are not free; they are the subhuman responses to a nonhuman world. To feel depressed in an alienating society is probably a healthy reaction, just as is feeling pain when touching a hot stove.

Another example of the societal impact on mental health is provided in the examination of the changing rates of admission to mental hospitals. Brenner's (1976) analysis finds that certain societal factors, that is, shifts in the economy, and specifically in the level of unemployment, are the most important sources of fluctuation in the rates of admission. When social times are bad, more people are in need of 'treatment.'

Societal factors do not solely consist of material or economic conditions; also important are the prevailing theories that inspire policy. Sedgwick (1982) submits the importance of this class of societal factors in accounting for certain periods of decreasing rates of admission to mental hospitals. He argues that the general decrease in such admissions during the 1950s until the mid 1970s is not easily attributable to new chemicals, because in some Western countries such as France and Italy, the advent of new drugs was not accompanied by a decrease in admissions. Rather, he maintains that the movement of patients out of psychiatric hospitals is best accounted for by the rise of right wing libertarianism. He points to the particular example of Ronald Reagan's California, noting that the number of in-patients in Californian mental hospitals was reduced from 50,000 to 7,000 between 1955 and 1973. With the closing of many institutions, this libertarian-inspired mental health policy has had serious ramifications for individuals' well being. Since no money was allocated for alternative solutions, "patients have ended up in prison, on the streets or just dying" (Sedgwick, 1982, pp.216-21).

Even Health and Welfare Canada (1988) makes the connection explicit:

Whatever makes it difficult for the individual, the group and the environment to interact effectively and justly (for example, poverty, prejudice or poor coordination of resources) is a threat or barrier to mental health.... [The] distribution of power among individuals, groups and their environments is a crucial determinant of mental health. (pp. 8 & 10)



The relationship between social circumstances and individual woes is apparent. Given the powerful role of psychologists, clinical practice could play an integral part in clarifying society's role, and thus participate in the political struggle toward human liberation.

### Therapy Ignores the Social

Mainstream clinical psychology does not help clarify society's role. On the contrary, psychologism privileges the unitary rational subject, or the self:

Psychology's subject is the individual [the unitary rational subject]. This individual is the transcendental subject of Western philosophy, the one whose essence precedes and is independent of experience or the social realm. (Hollway, 1989, p.28)

Psychology relegates social concerns to the background. Variables such as economic position, race, age, gender or sexual orientation are treated as extraneous factors, that only have a minor impact in shaping individual identities. At best, these are variables to be considered but not acted on (Prilleltensky, 1990b). This asocial image of the human being portrays the individual as essentially "independent from socio-historical circumstances" (Prilleltensky, 1989, p.801).

This heavy emphasis on individual functioning prevails in most present practices of clinical psychology. For example, whether psychoanalysis was originally intended by Freud to focus on individual, at the expense of societal, considerations is debatable. In fact, some interpret Freudian theory as a progressive tool for transforming society (e.g., see Jacoby, 1975). What is less controversial is that the American versions of psychoanalytic thinking, especially ego-psychology, watered down the so-called subversive aspects of the theory, in their attempts to accommodate to individualist and conformist ideology (Frosh, 1987; Jacoby, 1975; Turkle, 1978).

Frosh (1987) discusses how seemingly different schools of psychoanalytic thinking are surprisingly like-minded in their accommodationist tendencies. Apart from Lacanian theory, he

suggests that most other schools of psychoanalytic thought have an individualistic bent. For example, he claims that culture school theory fails to provide an account of the manner in which society penetrates individual consciousness. Similarly, the object relations position restricts its social vision to the mother–child network. Likewise, other therapy schools also focus heavily on the individual. For example, Rogerian therapy, Growth therapies, the Human Potential movement, and Experiential therapy rarely question the institutional context (e.g., see Bellah et al., 1985; Ingleby, 1981; O’Hara, 1989; Sipe, 1986). Behaviourism is even more extreme in its adoption of psychologism. It “masks social and moral conflicts with the appearance of being mere technical inconveniences” (Prilleltensky, 1989, p.798).

Psychology’s general obliviousness to social issues does not only affect its working theories. It also affects psychologists’ choice of clientele. One implication of a weak commitment to social responsibility is the persistence of a class–related differential in the availability of therapeutic treatments. That is, the high socio–economic status clients receive the most expensive therapies (Hollingshead and Redlich, 1958; Redlich and Kellert, 1978). Even when lower–status clients receive service, they are not bestowed the same level of caring and compassion afforded to people of backgrounds similar to that of the majority of therapists, that is, clients who are white, educated, urban and middle class (Sarason, 1985). Sarason (1985) argues that the choice to treat their own kind with more care and compassion is greatly determined by the professional socialisation process. He says:

It turns the compassionate student into the noncompassionate clinician, a process always articulated and cloaked in the garments of efficiency, objectivity, necessity, and a presumed superior level of morality. (p.23)

### Supporting Dominant World Views

Capitalism, consumerism and psychology all have a shared heritage, that is, a belief in the myth of the autonomous individual. Therefore, even though these two major tenets of

American life preceded its' ascendancy, clinical psychology has an active role in maintaining these organizational principles and their founding mythology.

With the development of the capitalistic market-driven mode of production, the conception of individual freedom and individual autonomy has become increasingly important. According to Corrigan and Leonard (1978),

it was necessary to capitalist production that individuals should be able to enter into 'free contractual relations'.... The dynamic of capitalist production required a social and physical mobility, a willingness to leave traditional ties and plunge into relationships which were dominated by the selling of the individual's labour power. Every individual had to have the liberty to sell on the open market his [sic] labour. (p.109)

This production system, based primarily on the profit motive rather than on human needs, is suffused with individual competitiveness, the motivation to achieve and succeed. Many commentators contend that for some people, the costs of this individualistic, competitive system are quite high. These costs include loneliness, alienation, privatisation, poverty, and the experience of powerlessness (Berger & Kyle, 1985; Corrigan & Leonard, 1978; Sarason, 1981b).

For capitalism to work, it is theoretically important that these human costs are not seen as inherent to the functioning of the mode of production. On the contrary, "it is essential that these characteristics of the competitive economy should be seen as the essence of the 'human condition'" (Corrigan & Leonard, 1978, p.112). That is, for capitalism to maintain its dominance, the source of such human suffering, indeed, the source of all functioning, must be understood as emanating from within the individual. As Jacoby (1975) insists, "the cult of human subjectivity is not the negation of bourgeois society but its substance" (p.103).

An individually oriented clinical psychology plays an important role in fostering this perspective. Clinicians help maintain this desired perception, given their inclination to respond to poverty, illness and deprivation, in individualistic terms, by helping people adjust to their circumstances. This approach is congruent with the conviction of most psychotherapists that

this society is a true meritocracy (Lerner, 1986). For example, humanist psychologists believe that alienation stems from a lack of sensitivity, and has nothing to do with the bourgeois mode of production (Jacoby, 1975). If workers are facing stressful work situations, therapists understand their task as helping workers focus on their personal contribution to the problem. Given this approach, there is little impetus for therapists to be familiar with the class structure of this society, let alone formally analyze class structure as a factor to be considered.

It is not difficult for therapists to avoid an analysis of structural factors, since clients also come into therapy with the assumption that they are the ones responsible for the failure of their personal lives and that they must change themselves (Lerner, 1986). Lerner goes on to comment:

Therapists confirm this analysis, by focusing attention on those aspects of their lives which have no social framework and that are not obviously related to issues of work, sexism, isolation, the breakdown of communities or the pressures of a competitive marketplace. If clients try to raise these issues they will be accused of seeking to avoid personal responsibility. (p.324)

With respect to consumption, "the role of the private consumer (has) acquired tremendous significance for the continuation and development of the capitalist system" (Corrigan & Leonard, 1978, p.111). Presently, ever increasing private consumption fuels the motor of capitalist society. The conviction that one attains personal worth only through conspicuous consumption is encouraged, given its centrality to the system's maintenance.

As with production, significant costs are associated with a society bent on consumerism. For example, Cushman (1990) suggests that consumerism contributes both to the creation and the maintenance of the 'empty self' syndrome. He defines 'empty selves' as the absence of community, tradition, and shared meaning, experienced as a lack of personal conviction and worth. He suggests that these absences result from a society of individuals who are consumed with consuming "goods, calories, experiences, politicians, and romantic partners" (p.600). In Cushman's formulation, these autonomous, masterful selves are

condemned to remain empty given the transitory nature of their panacea, that is, more consumption.

Again, through its individualistic theories, clinical psychology helps perpetuate the 'empty self' syndrome. That is, it combats the growing alienation of the empty self by admonishing consumers to fill up on new and improved individual experiences, supplied by empathetic therapists. Psychotherapy not only helps preserve the consumerist mentality; some brands of psychotherapy have themselves become consumer products. That is, the 'new consciousness' being promoted by the self-awareness movement in psychology is heavily packaged and marketed, much like any other commercial item (Schur, 1976). Castel et al. (1982) go one step further, suggesting that these 'experience industries' have become big business.

#### Techniques of Social Control

Corrigan and Leonard (1978) argue that the ruling class does not only rely on direct repression (e.g., by the army, the police, the courts) to maintain its dominance. They contend that the more subtle social power of other institutions, such as the mental health profession, is also implicated in preserving the hegemony of the ruling class. Without necessarily assuming the existence of a ruling class per se, Foucault also suggests that micro practices such as psychoanalysis help maintain social control. In presenting Foucault's view, Fraser (1989) says that psychology "replaces violence and force of arms with the 'gentler' constraint of uninterrupted visibility" (p. 23).

One way in which clinicians help maintain social control is through the transmission of socially sanctioned values, ideas and definitions. For example, the prevalent medical and psychological models of treatment that neglect structural factors in the creation of mental disorders have a societal stamp of approval. This neglect and concomitant focus on individualistic formulations is not only congruent with, but actually actively supports dominant

interests. As already suggested, to maintain ruling-class hegemony in the face of its ensuing social ills, the problems that confront society "must not be seen as a consequence of inherent contradictions in the system, but, rather, as the result of individual failure" (Corrigan & Leonard, 1978, p.101).

In a similar vein, R.D. Laing (1967b) suggests that the treatment of certain individuals who question symbols of authority, is politically motivated and is related to the preservation of the existing social order. He says that these individuals who question the legitimacy of certain institutional arrangements threaten the ongoing stability of these arrangements (Antonio, 1975; Laing, 1967b). Mental health professionals combat this threat through outright invalidation, or in some humanistic or psychoanalytic schools, through validation of the feelings, but not of the meaning of the action. They reprimand the doubters, by labelling them diseased or mentally ill, cast them out of society by warehousing them in institutions for 'their own good', or numb their ability to act on their beliefs by administering 'miracle' drugs (also see Rothaizer, 1979).

Though not as blatant in their analysis, other less flagrant left-leaning analysts present similar critiques of institutionalised psychologism (Barratt, 1988a, 1988b; Berger, 1965; Canguilhem, 1980; Homer, 1977; Maglin, 1978). They make the comparable claim that clinicians exercise social control by labelling individual complaints as symptoms of an individual's disorder rather than as evidence of social problems.

The gist of these commentators' critique is that traditional psychotherapeutic practice assumes the possibility of defining a state of normalcy, based on an absolute truth that resides outside the system of discourse.<sup>7</sup> The client, the producer of the discourse, is defined by the therapist as incapable of deciphering his or her own utterances. Therefore, it is the psychotherapist's job, as society's official interpreter, to furnish its meaning, and to provide the interpretation of what is true or normal. Part of what this therapist, as hermeneutic authority, then considers normal entails the client adjusting to a consensual reality. In practice, the

therapist's notion of normalcy translates into people being judged mentally ill or healthy according to their compliance with social norms (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1972; Feminist Psychology Group, 1975; Homer, 1977; Nowacki & Pope, 1973). Recovery from mental illness is then understood in terms of how well the individual has adapted to this truthful, normative way of thinking, and has adopted societal standards.<sup>8</sup>

This notion of normalcy undermines the possibility of implicating broad social issues in trying to understand individual problems. It is difficult for therapists to be critical of the societal status quo when they define normalcy as the capability to adjust without serious conflict to the norms of a given social environment. In fact, this definition of normalcy implies that "rebellion against the status quo is [itself] pathological" (Maglin, 1978, p.70). Rose (1985) recites the famous quote of Leriche, that 'health is life in the silence of the organs,' and modifies it: "Health, for the psychology of the individual, is not so much life in the silence of the organs as life in the silence of the authorities" (p.231).

### The Assessment Enterprise

Danziger (1990) tracks the enormous expansion in both the size and the scope of bureaucratically administered institutions during the latter part of the nineteenth century, especially in the management of social deviance and in the realm of education. With these increases, society's "need for special sorting practices increased greatly" (p.109). Confident in its emerging expertise in devising new scientific and statistical methods, psychology fulfilled this new position, as official societal sorter.

The strategy for sorting people, for doing assessments, was similar to the approach in therapy. In separating normal and deviant behaviour, psychology utilised this new scientific technology, defining the normalcy of a behaviour in terms of how far it deviated from a statistical norm. In theory, the development of these norms was defended on psychological

grounds; in practice, they were norms of social performance. For example, Danziger (1990) suggests that the study of human cognition was motivated by the desire to determine who would most effectively conform to certain socially established criteria. "They were always criteria that only made sense in the context of particular social interests, be they grand and ideological or practical and mundane" (pp.108–9).

To incorporate social considerations at this point would be absurd, given an 'objective' technology that is predicated on the belief that social circumstance is mostly irrelevant when categorising behaviour. Putting these two concepts together then, society is responsible for establishing the criteria for normalcy but the individual is understood as being responsible for any deviant response.

Some psychologists are quite explicit about the societal goals embedded in the assessment industry. One example of an assessment tool being devised and used to further specific societal ends has been Alfred Binet's intelligence test and its subsequent revisions. The fundamental reason it occupied such a prominent place in the structure of educational administration was that, according to Binet himself, "what it measured was [societal] adaptation" (Rose, 1985, p.129).

Interest in these (and other) adaptational scores has not been merely academic. Danziger (1990) argues that the results of assessments which clinical psychologists supply to certain social institutions, like schools, hospitals, and military institutions, are socially prized. The knowledge of such adaptational scores have been used historically to formulate new, and to rationalise preexisting, techniques of social control.

#### 'Value-Free' Scientific Statements

There are at least two ways in which the framing of clinical psychology's individualistic theory in so-called value-free scientific terms helps maintain the status quo. The first is that the use of value-neutral ideas lulls the public into a false sense of security. It "predisposes the



public to accept psychology's assertions uncritically and then regard them as apolitical truisms rather than [as] socio-historically conditioned statements" (Prilleltensky, 1989, p.797).

The second is that, by definition, value-free ideas are not imbued with power. Rather, they are meant to be merely descriptors of reality.

Repeatedly, in the course of history, the pronouncements of scientists have been used to rationalize, justify, and naturalize dominant ideologies and the status quo. Slavery, colonialism, laissez faire capitalism, communism, patriarchy, sexism, and racism have all been supported, at one time or another, by the work of scientists.... By draping their scientific activities in claims of neutrality, detachment, and objectivity, scientists ... absolve themselves of social responsibility for the applications of their work. (Namerwirth, 1986, p.29)

Merely describing 'the way things are' similarly absolves therapists from owning up to the political implications of their work.

Psychology's pretence of value-neutrality supports a liberal framework, that only recognises obvious manifestations of power (e.g. conspicuous displays of police power). Psychology's belief in its use of value-free ideas and its participation in this liberal discourse therefore functions as a means of masking the actual character of modern power and thus helps to conceal domination (Fraser, 1989).

### The Need for Self-Reflexivity

In order to develop a therapeutic practice that actively participates in the struggle for human liberation, therapists must reflect on how their present practices affect society (Maglin, 1978; Schur, 1976). Lax (1992) suggests that "reflexivity is the act of making oneself an object of one's own observation.... [That is] one is able to 'step aside' from the discourse one was engaged in and view it from another perspective" (p.75). I submit that reflexively adopting this other perspective requires a 'social' component. This entails the realisation and articulation of power relations existing both within the profession and with others, that is, how the therapist is

both an objective force in, and a subjective foil of history. Power relations exist on many different levels, for example, individual–society, client–therapist, therapist–institution, etc.<sup>9</sup>

Emancipatory therapy necessitates the adoption of a self–reflexive stance. This form of therapy, based on the theory that social forces and the conceptual meanings attached to them, saturate human existence on every imaginable level, is in sharp contrast with psychology's present infatuation with psychologism. To impart this alternative perspective to their clients in a morally responsible manner, it is incumbent on therapists to reflect on the social forces that permeate their own existence. For example, to accept the belief of the therapist as 'professional authority' helps mask the value base on which the notion of expert is built. Instead, it is necessary for therapists to reflect on their own roles, to examine their own values and to problematise the very notion of expertise.

In scrutinising her or his own cultural perspective, the psychologist would not only be setting an honourable standard for society at large, but would also be setting a good example for the client in the room. Theoretically, such a stance is especially compatible with the psychoanalytic perspective that maintains that each individual subvert in questioning all previous frameworks for understanding. Barratt (1984) maintains that good science demands an open mind of the scientist. Everything must be called into question; the scientist cum therapist must "refuse to grant any aspect of reality privileged immunity from reflection, interrogation, or inquisition" (Barratt, 1984, p.241).

### The Lack of Self Reflection

Many commentators argue that mainstream psychology pretends to be politically neutral. That is, psychologists generally do not examine their relative place and status within society, nor how their work reflects the relationship to that order (Habermas, 1970; Prilleltensky, 1989; Sarason, 1981b; Sullivan, 1984).

Sarason (1981a) offers a particularly telling example of this nonreflexive position. In reviewing Hilgard's (1978) collection of American Psychological Association (APA) presidential addresses, he comments on the presidents' conspicuous lack of contextualizing their particular theories. With one notable exception (John Dewey, in 1899), "one would hardly know that psychology existed in a particular society having a distinctive social order" (Sarason, 1981a, p.827).

This lack of self-reflection is consistent with psychology's heavy emphasis on individual functioning. Given the asocial nature of their working theories, it is counter-intuitive for clinicians to reflect on their place within society. Applying individualistic theory to their own station in life, psychologists are not predisposed to seeing themselves in society, but rather to seeing themselves and society, "a dichotomy that has made it easy for them to avoid confronting directly the nature of society" (Sarason, 1981b, p.26).

This nonreflexive stance is also supported by the profession's dominant political and metatheoretical perspectives. Politically, most therapists maintain liberal-humanist principles. These principles are so pervasive in contemporary Western society that "it is a rarely recognised and rarely questioned 'fundamental faith'" (Gavey, 1989, p.461; also Kitzinger, 1987). Liberal-humanists are not generally concerned with analyzing power relationships, the assumption being that everyone has an equal chance to compete (Dworkin, 1990).<sup>10</sup> Only when the danger is clear and obvious are power relations open for investigation. These threats include the exercise of undue power by the police, the legislature or the courts. Such investigations would not likely include examining the subtle, yet powerful influence of institutions that lack legal clout, e.g., clinical psychology (Sedgwick, 1982).

On a meta-theoretical level, the profession's guiding epistemology is firmly rooted within the non-reflexive, logical positivist tradition (Barratt, 1984; O'Donohue, 1989). The logical positivist tradition is consistent with the notion that reality, in the form of universal laws of

psychological functioning, precedes the existence of the individuals to whom the laws refer. These laws are believed to be stable, irreversible and deterministic. In this tradition, knowledge is accumulated within the framework of a regulative ideal of truth.<sup>11</sup>

This perspective allows the clinician to pretend that he or she is taking a neutral, objective stance, to stand outside of history so to speak, and to describe things as if they exist in some independent reality. Based on the Boulder model, the clinical psychologist is understood to be a scientist–practitioner, supposedly implementing neutral, 'objective' scientific findings in clinical practice.<sup>12</sup>

Given this logical positivist, 'either something is or is not true' mentality, some questions are considered beyond the pale, assuming even a limited form of self–reflexivity. For example, the logical positivist belief in the existence of discrete entities in reality allows for a clear distinction between material and psychic needs, as if an original fissure existed.

It capitulates to the ideology of the affluent society which affirms that the material structure is sound, conceding only that some psychic and spiritual values might be lacking. (Jacoby, 1975, p.49)

Within this belief system, therapists need not be concerned with their impact on society, other than as tenders of the psychic and spiritual needs of the community. Operating from an either/or framework, it is unlikely for such clinicians to inject notions of critical social theory into clinical practice. They might think that by adding societal interests into therapy, by definition something would have to give, that something being the clients' interests.

For a profession set within the logical positivist, either/or tradition, theorising the possibility of inconsistencies poses a serious theoretical conundrum, that is, how to ground action in a so–called relativistic universe. It would thus seem impossible to understand seemingly contradictory concepts in which to ground action, such as Gergen's (1991) notion of 'serious play.' There is either meaning or relativism, morality or a slippery slope, the latter options implying a potentially 'anything goes' mentality.

A number of additional factors help account for clinical psychology's maintenance of a positivist, nonreflexive stance. These include 1) Clinical psychology's desire for societal recognition, 2) The social context of the profession, 3) The manner in which therapists are trained, and 4) The belief that psychotherapy seems to work. Each one of these influencing factors are briefly discussed in turn.

#### Desire for Societal Recognition

During the late 1800s, psychology failed in its attempt to gain societal recognition through its links with philosophy, history, and anthropology. To attain professional status, psychology then changed its direction somewhat, becoming less of a purely academic discipline, and modified itself to society's increasing respect for science. With the growth in scientism, "[psychology] shifted ... and based its claims for recognition entirely on its affiliation with the natural sciences" (Danziger, 1990, p.41). More recently, the profession has derived its power base from the scientist practitioner model that is embedded in the non-reflexive logical-positivist tradition (previously discussed; also see Frank, 1987).

Sarason (1981a) suggests that the 1950 Boulder Conference, officially establishing the scientist practitioner model, legitimated an orientation that had already been established during and immediately after World War II. At that time, natural science was touted as the saviour of American society. There was general consensus that research within the logical positivist tradition was a credible base for restructuring America. Instead of questioning the basis for this agreement, clinical psychology joined it with a thorough commitment to a technological and scientifically based research program (Sarason, 1981b).

Adopting this perspective has helped clinical psychology justify its separation from philosophy (Sarason, 1981b) and has made it marketable, by fostering an expert professional status.<sup>13</sup> This acceptance included a devotion to such emblems of scientific status such as "quantification, experimentation, and the search for universal laws" (Danziger, 1990, p.120).

Psychology's enduring reliance on its interpretation of the prevailing public conceptions of the scientific method had begun.

### The Social Context

In North American society, procuring money is both a means of attaining, and recognition of, societal acceptance. Within this zeitgeist, funding issues have played an important role in the development of a technologically based, rather than theoretically based, profession.

After World War II, the U.S. federal government was willing to materially support scientific efforts within the mental health professions. This was predicated on the belief that science could help alleviate the nation's growing mental health problems, given the conviction that basic research leads to applied solutions (based on the 'success' of the atomic scientists [Sarason, 1981a; 1981b]). Not only did this funding source and the accompanying recognition encourage clinical psychology to focus its efforts in scientific endeavours. The profession figuratively 'sold its soul' through this intricate relationship with government. For example, the Veterans Administration (the VA) underwrote the graduate education and clinical training of more clinical psychologists than any other private or public agency (or any several combined) after World War II. That meant that "clinical training had to (literally) take place in VA hospitals and clinics, and that meant that the clinical trainees would never see children and would very rarely see women" (Sarason, 1985, p.148).

A more radical perspective suggests that the issue of funding has played a more direct role in clinical psychology's pretence at maintaining the attitude of neutrality. This view claims that it is difficult to be self reflexive when a proactive stance means criticising your benefactors. Given the possibility that the state is implicated in creating the structural conditions that produce the poverty and abuses of its clients, it seems contradictory that the

profession receives both its legitimation and primary funding from the same source, that is, the state (Ehrenreich, 1985; Gough, 1979).

Danziger (1990) proposes that historically, the marketability of its products influenced the direction of psychology's investigative practices. For example, the desire to be marketable, that is, to gain social acceptance and to generate funds, strengthened psychology's burgeoning ties with educational administrators. These ties further ensconced the profession within an objectivistic, scientific tradition, given that "the kind of knowledge that was most obviously useful in administrative contexts was statistical knowledge" (p.105).<sup>14</sup>

### Therapists' Training

Training within the logical positivist tradition contradicts the notion that reflecting on one's philosophical values is crucial to a therapist's education. On the contrary, the therapist is taught to distinguish between values and facts. Psychology programs teach what they consider to be most important, that is, scientific facts. They are less interested in examining amorphous values, such as the belief in personal agency, freedom and emancipation. "These concerns, which are moral in nature, one brings to the discipline" (Sullivan, 1984, p.175).<sup>15</sup>

To grasp abstract, metatheoretical concepts is especially demanding for the psychotherapy student, given his or her formal training in traditional scientific methodology (O'Donohue, 1989). "Present training in the field provides neither the skills [n]or [the] confidence to pursue research which could examine reflexively [its] own professional culture" (Berman & Segal, 1982, p.190). Therapists are rarely trained with any social perspective. For example, "social psychology courses are typically accumulations of facts about how people actually behave .., rather than an attempt to analyze how the structure of the society shapes individual psychology" (Lerner, 1986). Similarly, most mandatory ethics courses teach clinical students to be aware of therapists' responsibilities to their clients. There is less of an emphasis on being aware of the social and political ramifications of the job, or on taking social

responsibility seriously. Even if the student is interested in metaphysical notions such as self-reflexivity, and has been exposed to ideas of this sort (a rare experience in the APA approved clinical school setting), he or she would have a difficult time overcoming a limited philosophic background, given other clinical and research demands.

### Belief in Psychotherapy's Efficacy

Since Eysenck's (1952) scathing attack on the efficacy of psychotherapy in the mid 1950s, new and improved methodological studies suggest that psychotherapy works (see Luborsky, 1988). Given this general impression, therapists customarily rely on one of two strategies when faced with treatment failure. Rather than abandon their central belief in the therapy program, other factors are considered to have had more impact, e.g., "the client was insufficiently motivated or compliant, therapy was not long enough or was not properly administered" (O'Donohue, 1989, p.1466).

Alternatively, therapists take a traditional historical approach, believing that psychotherapy represents a progressive alternative to pills, hypodermics, and electricity (see Pilgrim, 1990, or the history of psychotherapy section in almost any introductory psychology textbook). This liberal, evolutionist interpretation of psychiatric history is countered by Foucault's (1967) claim that present day interventions are even more invasive than pills and electricity, since rather than attacking the physical body, they penetrate the inner recesses of the psychological being.<sup>16</sup>

In summary, I argued that clinical psychology helps perpetuate certain societal status quo arrangements (e.g., dominant world views such as capitalism and consumerism, as well as society's individualistic focus). A number of factors were adduced to help account for this support. Principal among them are its reliance on logical positivist metatheory, its individualistic conceptions, and its role in social control. The evidence suggested that, in adopting a so-called neutral stance, clinicians avoid scrutinising the impact that their work has



on society. It was proposed that the development of an emancipatory practice that critically questions the status quo demands of clinicians to reflect on their societal roles.

### Alternative Therapeutic Practices

Over the last 20 or 30 years, there have been a number of fragmented attempts outside of mainstream psychology to develop socially informed psychotherapeutic practices. Acknowledging the changing social times, it is informative to explore some of these previous efforts, to examine their successes at incorporating social theory into clinical psychology, and at developing emancipatory practices. In particular, I will discuss five of these efforts: 1) The antipsychiatry movement, 2) Alternative psychotherapeutic practices reflecting minority concerns, 3) Social constructionism and therapy, 4) Deconstructionism and therapy, and 5) Critical theory and therapy.

### The Antipsychiatry Movement

The antipsychiatry movement was born during the turbulent 1960s. As Sarason (1981b) comments:

With civil rights, gay rights, women's liberation, the war on poverty, black militancy, Head Start, urban social explosions, Vietnam, Students for a Democratic Society, [and] the Weathermen, "psychologists [among others] got caught up in the social hurricane." They tried to be "relevant," realizing somehow that they were not aloof from the social process. (p.36)

In their struggle to be relevant, 'antipsychiatrists' were like all other social reformers (or so it seems) in that they were neither a homogeneous group nor were they necessarily subversive. They appeared though to have a common theoretical point of departure — an anti-positivist position. The practitioners in this movement shared the desire to uncover the "interactive relationship [between facts and values], between the investigator and the 'facts' on which she or he works" (Sedgwick, 1982, p.23).

The movement's political projects diverged widely. To believe in the separation of facts and values does not commit one to a distinct set of values, nor to a particular perspective on society. Therefore, antipsychiatrists comprised a relatively diverse group of people; for example, Thomas Szasz, a right wing libertarian, the marxists R.D. Laing and David Cooper, and sociologist Erving Goffman, to name a few (Sedgwick, 1982).<sup>17</sup> One way to understand the group's relative heterogeneity is to posit the existence of two very different critiques of traditional psychotherapy that informed their guiding theories — humanism and socialism. The political ramifications of each perspective often differed, leading to many contradictions and debates within this loose association of theorists and practitioners.

Underlying the humanist critique was a romantic perspective that criticised traditional practitioners of psychotherapy for trying to be efficient state-employed workers, who did not pay enough attention to the inner soul. The basic unit of analysis for these humanist practitioners was the individual 'essence,' given their strong belief that people possess an essential goodness and creativity.

Carl Rogers, though not generally regarded as an anti-psychiatrist per se, epitomised the humanistic approach to doing therapy. He believed that mental health's prevailing focus on what was wrong or 'disordered' with people masked their underlying ability to creatively adapt to changing circumstances. With the help of a supportive and nurturing environment, he believed that individuals could grow by tapping into their essential and authentic goodness (Gergen, 1991; Jacoby, 1975).

Thomas Szasz's brand of humanist practice was somewhat different. His belief in a radical individualism, that the individual should be as free as possible from state constraints, was consistent with his libertarian politics. This stance compelled him to strongly oppose the coercive elements within institutional psychiatry (Sedgwick, 1982).

Many of these humanistically inclined practitioners were criticised by another loosely associated group, that is, by socialist-informed clinicians. The latter's major objection concerned the humanist notion that the 'subject' is somehow immune from society. They took issue with the humanist affirmation of an essentially Cartesian self-consciousness, that the individual can be regarded as a self-contained unit, dependent solely on his or her own resources for growth. They disagreed with humanistic theorists who believed that social change is unnecessary for individual liberation, and who offered "the promise that one could escape from society into self-actualization" (Turtle, 1978, p.226). According to those with a socialist bent, not only was this individualistic based theory lacking any subversive critique of larger social institutions, it was also partly responsible for diverting attention from important societal issues (Prilleltensky, 1989).<sup>18</sup>

In the effort to focus more attention on social issues, these socialist anti-psychiatrists attempted to inject socialist theory into the therapeutic framework. For example, Cooper and Laing broadened the scope of individual therapy by examining the social context in which behaviour occurs. In particular, they developed a social phenomenological approach to the study of schizophrenia. This entailed an examination of the network of concrete human relations in which the schizophrenic finds him/herself. They focused on family relationships as the impetus for the schizophrenic strategy which, as they understood it, a person invents in order to live in an unlivable situation.

As with the humanist practitioners, serious divisions also existed within the socialist group of antipsychiatrists. Maglin (1978) discerns three main trends within the radical therapy movement. The first trend he labels 'aggressive radical therapy,' based on the notion that people ought to be radicalised through the therapeutic process. The second trend, 'defensive radical therapy,' he understands to be less radical in nature. It did not perceive the role of therapy as creating a pervasive socialist consciousness, which from this perspective was

considered to be generally impossible in the therapeutic context. Rather, the role of therapy was to foster sufficient social awareness, helping people cope with a non-supportive, oppressive, and authoritarian social order. The final trend he identifies as 'social radical therapy.' In this conception, the word therapy was used metaphorically, since the conventional notion of therapy was abandoned in favour of seeing society as the patient.

Castel et al. (1982) offer many examples of how these important differences among socialist-inspired practitioners played themselves out. In one illustration, they sketch the brief history of clinical psychology's leading radical journal of the time, Radical Therapist. They trace how the debate concerning therapy's role within socialism precipitated the journal's splitting into two separate publications, RT and Issues in Radical Therapy.

Several criticisms have been levelled against these socialist leaning antipsychiatrists. Some critics claim that their loyalty to socialist ideology was only skin deep. For example, Philip (1985) writes: "Cooper seems to see ideology as something which could simply be torn away to reveal the essential subject beneath" (p.155). Similarly, Sedgwick (1982) claims that Laing's emphasis on the family unit certified his membership in the 'cult of immediacy.'

Sedgwick says that Laing

was among those for whom small-scale structures and relationships were more real than the larger complexes of society because the former were more direct, more 'personal.' (p.114)

Jacoby (1975) suggests that the left-leaning antipsychiatrists never practised social critique, and did not place enough emphasis on social class as a particular, decisive mediating agent in mental illness. More generally, this attempt at uniting socialism and psychology was criticised by its reductionistic approach, by "its inability to retain the tension between individual and society, psychology and political economy" (Frosh, 1987, p.142; also see Brooks, 1973).

Brown (1981) counters these, suggesting that they ignore some of the political activism and theoretical legacies of antipsychiatry. He suggests that a contextual reexamination reveals comparatively positive contributions, relative to the mainstream practices prevalent at the time.

### Minority Concerns and Psychotherapy

The explosive growth in the number and reach of alternative psychotherapies that reflect minority concerns came on the heels of the antipsychiatry movement. The relatively recent proliferation of feminist informed practitioners, therapy oriented to the concerns of gays and lesbians, and therapists who prefer to work as advocates for visible minorities and disadvantaged groups, along with professional journals dedicated to each, highlight this change in practice.<sup>19</sup>

As with the antipsychiatry movement, the methods employed by these alternative therapists are as diverse as the minority groups which they represent (Castel, et al., 1982). It is acknowledged that each collective has special needs and each constructs meaning in a particular fashion. However, in the interests of brevity, the present discussion is limited to some of their important commonalities.

Rose's (1990) formulation of three basic principles of advocacy/empowerment therapy developed over the last 20 years embodies the main thrust of these alternative approaches. The three principles are: 1) Contextualization, acknowledging the social being of the client, recognising that the client is an expert concerning his or her own social (racial, ethnic, cultural, etc.) experiences; 2) Empowerment (traditionally defined, see previous discussion), supporting the client in expanding the range of possibilities to meet his or her needs; and 3) Collectivity, helping the client reduce isolation and the terror of experiencing oneself as uniquely defective and stagnant.

Arguably, therapists who adhere to these principles go far in making the therapeutic enterprise more relevant to previously disadvantaged groups. In that these principles question the notion of expertise, support alternative constructions of reality, and have intrinsic social components, they are a good blueprint for a critically informed practice. In fact, Castel et al. (1982) suggest that employing these principles in therapy has led to a politicisation of certain areas of private life, has raised consciousness about certain social problems, and has stimulated new forms of collective action, such as the free clinics and the Community Mental Health Centres.<sup>20</sup>

However, a different reading of history suggests that these therapeutic practices have left a contrary legacy. In their quest for practical survival, many of these alternative therapists compromised their principles to secure monetary support and societal recognition (where have we seen this before?). For example, Castel et al. (1982) discuss how the need for credibility and money led the free clinics of the late 1960s, centred in Boston and San Francisco, to acquiesce to outside controls. They accepted a board of directors who demanded that illegal drugs be kept off the premises, and they hired state licensed professionals who were trained in traditional methods.

Goldner (1991) also discusses how some of these practitioners were trapped in the status quo. She argues that, in reaction to the distortion of the prevailing totalising, normative theories, feminist practitioners have been reluctant to use any theory not directly arising from the therapeutic conversation. Miring themselves in subjectivity, "[a] devitalizing process was activated in which feminism imploded in on itself, leading to a self-referential psychopolitics that lost its political grip" (p.100).

Enns (1993) also argues that recently much of feminist therapy has undergone a de-radicalisation process. For example, during the 1970s, she maintains that the use of diagnostic testing was eschewed by many feminist therapists, and that feminist counselling groups

emphasised the shared oppression of women and the external sources of problems. By the mid 1980s, diagnostic testing was condoned, with the new aim being the elimination of bias in standardised tests. In addition, feminist counselling groups changed dramatically, tending to focus on specific issues rather than on general or interpersonal themes. Enns suggests that,

given the changes in group structures, it has become more complicated for therapists to draw consistent connections between the personal and political issues of diverse groups of women. (p.39)<sup>21</sup>

Alternatively then, assuming Foucault's perspective, one of the more insidious possibilities is that the spread of these alternative forms of therapy to heretofore untapped client markets, given their inability to disassociate themselves from traditional subjective metatheory and social constraints, have helped perpetuate and expand the dominance of the pervasive ideology. Paradoxically, in their conscious attempt at social change, these alternative therapists might have fostered the conversion of more and more people into the age of psychologism. It is conceivable that psychiatric imperialism changes and expands, as it feeds off its adversaries.

By definition, an oppositional movement as it gains institutional legitimacy surrenders part of its very essence or core (using psychological terminology). Turkle (1978) interprets the medicalisation of American psychoanalysis in these terms:

The impact of the medical legitimation of psychoanalysis has been so great that most Americans have stopped thinking about the existence of contradictions at all.... Some discuss popularity in apocalyptic terms. They fear that when psychoanalysis becomes the "thing to do" it means the end of psychoanalysis. Their experience leads us to wonder if psychoanalytic subversiveness depends on psychoanalytic marginality. Psychoanalysis, like anarchism, is a system designed to break down systems. Does the continuing power of the psychoanalytic movement, like that of anarchism, depend on permanent revolution? (pp. 12-15)

Perhaps a similar analysis is relevant with respect to these alternative therapists.

On the other hand, Castel et al. (1982) suggest that even though some feminist therapists emphasise individual experience and subjectivity (traditional concepts) others have

tried to relate social causes to their personal alienation. For example, Laidlaw and Malmö (1991) maintain that most feminist therapists still reject the adjustment model of mental health for women, understanding that the social context is also in need of change. Some forms of Gay and Lesbian therapy are another example of successful compromise in action. "The main goal was personal, to change negative self images into positive ones. However, the client was not intended to conform to traditional social values" (Castel et al, p.241).

### Social Constructionism and Therapy

More recently, a number of marginalised therapists (including some feminists) are considering other metatheoretical perspectives on which to support the development of critically informed clinical practices. One such perspective gaining some favour is social constructionism. Prior to examining how social constructionism is used as the basis for developing such practices, I will provide a brief sketch of this theoretical approach.

Social constructionism is predicated on taking individual subjectivity seriously. In this approach, interpretations of reality derive for a pragmatically inclined 'subject.' However, this orientation differs from an exclusively 'subject' driven approach (such as phenomenology) in its recognition that the individual experiences the world in a particular social context.

Berger and Luckman (1966) are generally credited with being the founding members of the social constructionist movement. In devising a sociology of knowledge, they are not concerned with the existence of ultimate realities. Rather, they are interested in what people pragmatically 'know' as 'reality' in their everyday, non- or pre-theoretical lives. They believe that "commonsense 'knowledge' rather than 'ideas' must be the central focus for the sociology of knowledge" (p.14). The focus of their inquires is not on the epistemological basis of events, persons or objects. Rather, they focus on how events, persons and objects gain pragmatic meaning. In general, they suggest that meaning is not based on stable, trans-historical and



universal truths. Rather, meaning has a pragmatic basis, in that it pertains directly "to present or future actions, which is shared with others in a taken-for-granted manner" (Berger and Luckman, 1966, p.36). The meaning which these events, persons and objects, hold for individuals are socially constructed, in that they arise in a particular social context. Over time, these socially constructed meanings are experienced as objective reality, as they become repeated, habitualised, and institutionalised.

In McNamee and Gergen's edited book, Therapy as social construction (1992), a number of practitioners describe how they combine social constructionist theory and therapy. Focusing on their similarities, these practitioners generally agree that the therapist does not search for prior, hidden meanings in their client's stories. There is no hidden 'self' to be interpreted. Instead, lacking the necessity either to adhere to an invariant story or to search for a definitive account, multiple new ideas or meanings emerge from the non-instructive interaction between the therapist and the client. The therapist and client co-create new meanings, allowing the client to shift "current 'problematic' discourse to another discourse that is more fluid and allows for a broader range of possible interactions" (Lax, 1992, p.69). In the act of co-creation, the notions of therapist as expert, and client as being disordered and in need of expert treatment, lose credibility.

The individual is viewed as a participant in multiple relationships with 'the problem' only a problem because of the way it is constructed in certain of these relations. (Lax, 1992, p.251)

In constructionist therapy, clients guide their own treatment:

They are freed to investigate, experiment with, and invent meaning of their own -meaning that may be more compatible with their needs than those with which they started. (Efran, Lukens, & Lukens, 1990, p. 53)

Social constructionist therapy is antithetical to the traditional therapeutic goal of building or restoring 'essence.' For example, Erik Erikson's theory of development proposes that the major achievement of normal development is a fixed state of identity. For Carl Rogers,

restoring essence means becoming the authentic, true self (Gergen, 1991). From the constructionist perspective, the project of helping clients explore, rather than escape from, continuous flux is different indeed.

Social constructionist therapy does an adequate job promoting most of the values being advocated here, e.g. it is non-absolutist in that it takes the separation between values and facts seriously, and it allows for self-reflexivity. Far from presuming privilege for the therapists' power of interpreting cause, social constructionist therapists challenge the very notion of cause. They reexamine their own constructs that perpetuate limited causal notions.

However, it is questionable how well this approach supports a socially informed therapy, per se. Social constructionism's questionable legacy in this regard may be illustrated by examining Lincoln and Guba's (1985) popular version. In offering a relationship-based ontology, they suggest that meaning is created through an interactive process of shared constructions. From their perspective,

realities exist in the form of multiple mental constructions, socially and experientially based, local and specific, dependent for their form and content on the persons who hold them. (Guba, 1990, p.27)

In another work, Guba and Lincoln (1989) recognise that these constructions are theoretically linked to the particular physical, psychological, social, and cultural contexts within which they are formed and to which they refer. However, even this work is focused almost exclusively on the shared constructions of those in the immediate context, and their offered methods for analyses down-play the importance of societal power structures.

Some commentators have attempted to remedy this perceived oversight, by expanding social constructionism's terms of reference. They have argued that notions about the nature of reality are unintelligible apart from the social process within which they emerge. In particular, in analyzing deep societal structures, these commentators have demonstrated how the power

structures that inhere within social processes are key components in interpretation (e.g., Minton, 1986; Sullivan, 1984; Unger, Draper & Pendergrass, 1986).

Most social constructionist therapists have disregarded the efforts of these commentators, following instead Lincoln and Guba's lead in down-playing the role of societal power structures. For example, only a small minority of the practitioners in McNamee and Gergen's edited book (1992) discuss the role of power politics, most notable among them being Lax (1992), and Efran and Clarfield (1992). That is, the vast majority of contributors appear to ignore the possibility that social power plays an important role in their clients' lives.<sup>22</sup> In fact, Lax (1992) indicates that Gergen himself makes the argument that, "understanding arises not through an examination of deep structure, latent or unconscious material, but through interaction between individuals" (p.73). Other social constructionists believe that concepts such as deep structure or power are themselves constructions. For example, Cecchin (1992) believes that "people create the idea of power and then behave as if power existed. Power is created by the context and is invented by the protagonists of the situation" (p. 89).

Hare-mustin and Marecek (1988) suggest that a social constructionist approach that favours the generation of a multiplicity of alternatives or marginalised meanings allows therapists to inject a social critique into their work. Though theoretically compelling, it is questionable whether their understanding represents the prevailing conception of social constructionism.

### Deconstructionism and Therapy

Deconstructionism has the potential for serving as a corrective to the somewhat narrow focus of social constructionism. It can be used generally, to critique the therapeutic enterprise, as well as more narrowly, to enable therapists to analyze how societal power arrangements

affect clients' functioning. Prior to discussing how this method can be used in both of these contexts, I will introduce Derrida's version of deconstructionism.

As the word implies, deconstructionism is best understood by what it criticises. It criticises the possibility of pure being, of an unmediated presence, denying the existence of any immediately available area of certainty. It denounces logocentrism (a belief in some ultimate word, presence, essence, truth or reality), and the logocentric ideal, that truth is expressible and graspable, and is attainable through logos, or reason (Sarup, 1989).

Since reality is not directly knowable through our senses or through reason, deconstructionism privileges language as the principal mediator of understanding. However, it overturns the classical notion of language, that words represent a pre-existing reality, that a sign signifies a signifier. Rather, it suggests that language is a sign, and unto itself it is both a signifier and the signified. Crucial to this approach is the notion that words do not simply signify signifiers, partly because their opposites inhere in them. For example, the word big does not directly reflect an ideal form of bigness. Rather, it is a relative concept, unintelligible apart from an understanding of the concept small.<sup>23</sup>

The aim of the deconstructionist method is to reveal the oppositions hidden in texts. However, it is not generally concerned with every opposition that lies dormant in everyday language. Rather, it principally is concerned with revealing hidden metatheoretical assumptions having a social basis (Sampson, 1991). According to this perspective, text consists of binary opposites. The deconstructive method involves first identifying the hierarchical oppositions within a text. They are usually indicated through an examination of the inconsistencies in a text. Next, the privileged term is placed under erasure. That is, the term's existence is acknowledged, but putting a metaphorical X through it signifies that its opposite or antithesis inheres in it. This is the revelation of a paradox, of contradiction and of the absence

of things that are present. Revealing the tension between the two, between the said and the not said, creates the potential for a new understanding to emerge.

This new understanding is not a duality of either/or between words and meanings, but a shift, at a minimum, to a both/and position. With this interplay of the said and the not-said, the present and the not-present, there is always the potential of another position or perspective, which has not yet been distinguished, to emerge. (Lax, 1992, p.72)

In developing this new position, the oppositional or weaker term may be extended to include the dominant one. In any event, the originally privileged term is reduced in status to that of the weaker term, and the conceptual opposition is temporarily dismantled.

As already stated, deconstructionism reveals the implicit ideological assumptions used in language. Therefore, the idea is not to privilege the original so-called weaker term. Its meaning is as prone to reinterpretation as is any other. Recognising the inherent inadequacy of any term condemns us to remain within the system of language, within an interpretive system where terms necessarily depend on their opposite for their meaning (Sarup, 1989).

The use of deconstructive methods could help reveal broadly based hidden metatheoretical assumptions underlying the therapeutic enterprise. For example, one could use these methods to deconstruct the role of therapy in society. One could place the relationship between the therapist and the client under erasure, putting a metaphorical X put through it, to signify that such a relationship is necessary but does not sufficiently describe the effects of the therapeutic encounter. The 'not said,' or the absence of things that are present can also be made explicit, for example, how therapy fits into society at large.

In addition, in deconstructing the client-therapist relationship, it is arguable that a therapist 'uses' his or her clients: for money, for the therapist's own sense of power and prestige, or perhaps for ideological reasons, e.g., to uphold the status quo. Some commentators wonder whether, in order to fulfil its own agenda, the therapeutic profession in a

sense 'creates' its own clients. For example, Jerome Frank suggests that the mental health industry may be generating its own customers.

The greater the number of treatment facilities and the more widely they are known, the larger the number of persons seeking their services, he states. Psychotherapy is the only form of treatment which, at least to some extent, appears to create the illness it treats. (Frank, cited in Gross, 1978, p.16)<sup>24</sup>

Within the deconstructive framework, it is incumbent on therapists to reflect on their use of social power. However, it is important that they avoid the trap of discussing these issues with their supervisors behind closed doors, while presenting to their clients a facade of expertise. Instead, deconstructing the notion that anyone actually possesses an immediately available area of certainty, therapists should reflect on these issues with their clients, treating them as equal partners. In this model, both therapists and clients are assigned the mantle of expertise, each bringing unique and important perspectives to the task.

In a narrower vein, deconstructionist methods can also be employed within the therapy context itself. By helping reveal how language is socially construed, deconstructionism can support socially informed therapeutic practices. Applying these methods to clients' verbalizations, therapists' could uncover its contextual nature. Helping reveal clients' implicit ideological assumptions is akin to the facilitation of clients' empowerment through emancipatory means.

Unfortunately, the literature dealing with the concrete use of these methods in therapy is quite modest. Among the few contributors in this field are Hare–mustin and Marecek (1988), and a handful of family therapists such as de Shazer (1991), and White and Epston (1990). In addition, how successful these contributors have been remains to be seen. For example, in their relatively short article, Hare–mustin and Marecek suggest that the therapist's task of listening and responding to clients' narratives is akin to a deconstructive reading of a text. They say the following:

Both seek to uncover hidden subtexts and multiple levels of meaning.... Just as deconstructive readings disrupt the frame of reference within which conventional meanings of a text are organized, so a therapist's interventions disrupt the frame of reference within which the client sees the world. (p.461)

Approaching therapy in this way has the potential for revealing contradictions or paradoxes in clients' pronouncements. However, they do not spell out how this would necessarily lead to a disruption of the ideological underpinnings of clients' verbalizations.

With respect to the family therapists, Fish (1993) maintains that de Shazer's, and White and Epston's methods, lead clients to question conventional understandings but they also "perpetuate the constructivist neglect of social context and power" (p. 220). In describing this critical shortcoming, Fish says the following:

Enabling someone to shift from a story in which the person is a "mental patient" who always fails, to a story where she or he often succeeds, is important. Getting to a story where she or he is "normal" and not a "mental patient" at all is even more beneficial. But neither shift necessarily challenges the discourse about normality and mental illness: if anything, such shifts may reinforce it. (p.223)

That is, a shift to a more positive narrative discourse is not identical to revealing the role that power and social context play in the hidden metatheoretical assumptions still operating in the discourse itself.<sup>25</sup> What is needed is a more explicit incorporation of an ideological critique that could lead to clients' attainment of emancipatory knowledge.

### Critical Theory and Therapy

Situating therapy within the critical social science tradition facilitates an examination of the role of power and of social context within therapy.<sup>26</sup> More particularly, grounding therapy within "the Frankfurt school [tradition] and its concern with questions of domination and resistance at the level of subjectivity" (Lather, 1991, p.109), permits an explicit analysis of the ideological underpinnings of clients' pronouncements, helping them to attain emancipatory knowledge.

One particular theory which emerges from the Frankfurt school tradition of critical social science, and that can be applied to therapy, is Adorno's (1966) version of dialectical theory. Prior to discussing how this theory can form the basis for emancipatory therapeutic practices, I will briefly introduce critical social science and Adorno's theory.

Critical social science pursues a critique of the deep structures of society and of certain constricting forms of thought. It makes the assumption that "people are very often unaware that they are enmeshed in patterns of distorted communication" (Smith, 1990, p.180).<sup>27</sup> To help people become aware, critical social science embraces a critical version of hermeneutics. It seeks to uncover the causes of distorted communication, and the contradictions embodied within modern society. Its main focus "is on the ideological distortions inherent in a broad range of historically formed social and cultural conditions" (Smith, 1990, p.181). It offers a way to expose these distortions, by privileging history, economy, values, and power relations (Lather, 1991; Popkewitz, 1990).

Adorno's (1966) negative dialectics offers a method for exposing these distortions. It assumes the existence of binary opposites, theses and antithesis, that are intrinsically related. These opposites form the basis of the never ending search for an unattainable truth. This search is conducted through an analysis of contradiction and negation. Through this type of analysis, theses are incorporated with their opposites, antitheses, in the creation of new syntheses. These syntheses, that accommodate and are congruent with the previously contradictory views, become the new theses that spawn their particular antitheses, and so on and so forth (also see Benack, Basseches & Swan, 1989; Georgoudi, 1983; Riegel, 1976).

Dialectically informed clinical practice focuses on the need to synthesize one particular strand of the dialectic, that is, the individual–society dialectic. In integrating the two, it strives to take psychic and societal formulations equally seriously. One previous attempt at incorporating the two is Jacoby (1975). He relies on the Frankfurt critical theory school of



Marxism (with which Adorno was associated), that tries to integrate Marx's theory of the state with Freud's theory of the individual. According to Jacoby (1975), the Frankfurt school interprets the Freudian conception of the individual as embodying society, that in a unitary, non-dualistic universe, the individual equals society. It is not that the society impacts on individual functioning, which would be an extension of Cartesian thought. Rather, the individual is society, and vice versa; this is true even intra-psychically. From this perspective, individual therapy is truly dialectical, equally affecting both the individual and society. Within this position, the expertise of the therapist lies in the ability to meaningfully articulate both thesis and antithesis, both the private and the social, with the explicit rejoinder that the particulars of the synthesis is ultimately subject to further construction.

Employing a dialectical framework, Efran et al. (1990) offer the following rationale for their practical incorporation of socially relevant discourse in therapy:

It is useful to have the freedom to change "lenses" from time to time, first using one level of analysis and then shifting to a larger, smaller, or different unit of study. Each analysis opens up fresh possibilities for intervention.... Each way of "chunking" events leads to different investigatory pathways and, potentially, to different discoveries, conclusions, and interventions. The individual, the couple, the family, the extended family, the client-therapist team, the community, and the ecosystem are all potentially productive investigatory units. (p.95)

Gerber (1990) also does not believe that incorporating socially relevant concerns into therapy is a useless or a counterproductive exercise. He says that the most efficient way to broaden the dialectic, to take individual and social considerations equally seriously, is to explicitly ask his clients whether they have any social concerns. He does not equate this approach with giving the therapist carte blanche to talk about anything she or he fancies. As he says, "I did not feel that asking about issues of concern to all of us was frivolous" (p.481).<sup>22</sup>

Asking about social concerns does not negate the importance of clients' subjective experiences. Rather one must constantly reflect on the dangers of objectifying an ideological critique. As Lather (1991) reminds us, "there is no final knowledge" (p.111). However,

incorporating an ideological critique in therapy frees us from mainstream psychology's exclusive reliance on psychologism.

### Examining the Alternative Approaches

A number of concerns regarding the prudence of developing any type of socially informed clinical practice have been raised. Some of these concerns are presented, followed by the rejoinder that these alternative approaches can indeed form the basis for a socially informed clinical practice.

No matter how 'social' therapy is, if the public perception is that therapists are treating individual ills, then the profession might inadvertently be a detriment to social change. Extending Foucault's notion of productive power (that is, internalising systems of self-interpretation that discipline the subjectivity of individuals from within), the way in which clinical psychology helps structure self-consciousness may be contrary to facilitating empowerment, and hence societal change.

Therapists who facilitate their clients' empowerment engage their clients in the political act of understanding how societal factors contribute to powerlessness. Practically, it has been argued that these same therapists contribute to their clients' depoliticisation. That is, it is typical for well intentioned therapists to respond to the social pressure to make people's lives a little bit better by sometimes offering immediate individual solutions to long term social problems. This response could serve as a disincentive to clients, who suffer from social oppression, from partaking in social change activities. As Jacoby (1975) argues, the impetus for social change from those who are energised because they are most directly suffering, may therefore be lost.

Therapy may not be the only culprit. The critical edge of a 'psy' society with a strong political flavour may be duller than intended. Turkle (1978) offers French society as an example:

The marriage of psychoanalysis and radical politics may not work.... The May events [of 1968] left a political legacy to French psychoanalysis, but the ensuing psychoanalytic culture also took many people who had been working for social change and refocused their energies on the possibilities for personal change, a pattern not unique in the history of failed revolutions. (p.219)

This might also be true in the North American context. Rather than working towards their stated goal of social change, Turkle (1978) suggests that the human potential theorists of the 1960s defeated themselves, "offering the promise that one could escape from society into self actualization" (p. 226). In addition, knowing that therapists treat clients individually, legislators might be led to believe that problems could be dealt with on a personal level, and hence spend less money and energy trying to alleviate societal ills (Albee, 1981).

Even if political change is possible through the therapy room, some question whether the individual client has contracted for societal change. Ingleby (1989) suggests that "if psychologists want to help the politically oppressed, they must appreciate that this task to a large extent falls outside the mandate that they have as professionals" (p.20).

Another challenge to emancipatory therapy comes from the psychoanalytic quarter. To remind the reader, I have defined emancipation as necessarily having a political component, that the ensuing self knowledge

must involve insight about social relationships in society which are based on power inequities .... which will liberate (us) from unnecessary forms of social domination. (Minton, 1993, p.7)

Given this definition, it would be the therapist's obligation to aid the client in this contextualizing process. However, some psychoanalysts, most notable among them, Barratt (1984,1988a, 1988b), take exception to explicitly sanctioning emancipation, as it is here prescribed. Based on his reading of Freud, Barratt vigorously refutes the idea that therapists

should pretend to possess any sort of prescriptive role. Since he considers the psychoanalytic undertaking emancipatory only vis-à-vis the repressed unconscious, he rejects the notion that therapists should offer a worked out emancipatory project. He is clear that therapists should not direct their clients to make informed choices based on their interpretation of existing forms of social domination. Barratt believes that no aspects of reality, including the analysts' interpretations, should be immune from reflection. As he says, all semiotic understandings tendered by well meaning therapists would end up only "collaborat(ing) ideologically in curtailing and constraining the being of things" (Barratt, 1984, p.208). His theory contradicts other alternative approaches that explicitly extol the virtues of helping direct clients towards emancipation (e.g., see Dworkin, 1984).

#### Rejoinder

Some of the arguments regarding the prudence of developing socially informed clinical practice have already been refuted. For example, Ingleby's (1989), and Barratt's (1984,1988a,1988b) reasoning, that it is outside the therapists' mandate to meddle in social issues, has already been rejected. It is impossible for therapists to stay above the political fray, and completely divorce themselves from their own values. Therapists can either choose to communicate to their clients the values of the dominant culture, or they can choose to facilitate alternative understandings, but they cannot stay neutral, since therapy is a political process.<sup>29</sup> Insofar that therapists constitute a powerful force in society, the particular values which they ultimately choose to promote not only affects the functioning of their individual clients, but also has far reaching societal ramifications.

The argument that psychotherapy sometimes deflects clients' energies away from social activities appears more compelling. However, one must balance this potential hazard with the fact that therapists help improve the lives of people in need. In addition, through

helping such individuals, it is conceivable that these individuals will then be able to expend the requisite energy to engage in social transformation (Prilleltensky, 1994). Further, the power of therapy has the potential to be an important agent of criticism and political change. As Frosh (1987) says:

Even when it restricts itself to the personal concerns of individuals...[it] offers a means of understanding how the world can be 'revealed' and expressed in the experience of every individual. (p. 13)

Through the ripple effect, this greater self understanding may also lead to a deeper sensitivity to the needs of others (Lakin, 1988).

Implicit in the above discussion are a number of principles meant to guide the development of an emancipatory therapy practise that benefits both the individual as well as the community. Chief among these is the notion that mainstream psychologistic explanations are not necessarily helpful to clients or to others. Emancipatory therapists should not thoughtlessly view social problems in terms of psychological maladjustment, that is, they should not neglect the role of external factors to explain problems that clients' experience. More generally, they should explicitly reflect on their values underlying their practice and on their effects on society. They should also reflect on the implications of being viewed as expert interpreters. Forsaking the expert model, they should help empower clients to make their own choices. At the same time, they should offer an analysis of the societal causes of powerlessness, privileging a critical understanding of ideology. In developing a dialogical relationship between therapist and client, this and other interventions should be carried out in a collaborative spirit, that supports the potential emergence of alternative constructions of reality.

I propose that emancipatory therapists adopt dictates similar to Prilleltensky and Walsh-Bower's (1992) moral imperative. Thus, they would be contributing to the 'good' society by reflecting on the social consequences of their work, by respecting the capacity of their

clients to select their own goals and to defend their own interests, and by pro-actively taking actions intended to foster the well-being of both their clients and the entire community. Therefore, instead of throwing the baby out with the bath water, I suggest that they substitute emancipatory goals for administrative goals, so that the positive aspects of therapy can be maintained.

These suggestions are consistent with my own Marxist-humanistic perspective. As already described in a previous footnote, I interpret this perspective as honouring and respecting individuals' choices while simultaneously taking into account the societal power structures that fundamentally affects everybody's ability to make choices.

In summary, a number of alternative approaches that have been more or less successful in generating critically informed therapeutic practices, were presented. Some concerns involving the legitimacy of developing these practices were also raised. In response to these criticisms, it was reemphasised that political neutrality is impossible. That therapists are in the position to deal with issues of domination and power inequities permits the continuing emergence of emancipatory clinical practices. Further development of these practices will help therapists take their social responsibilities seriously, and sensitise them to their role as social change agents.

### Second Part of the Research Project

In the rest of this research project, I will attempt in a more direct fashion to expose, deconstruct and reconstruct the discourses which therapists bring to therapy, so that we might have a clearer understanding of their role in the psychotherapeutic process (Lax, 1992). It is hoped that this exercise contributes to psychotherapy's having a more positive impact on its clients and on society at large.

In general terms, discourses delineate all social interactions and they signify the political system of relations in which communication takes place. They "signal the inescapable political context in which we speak and work" (Lather, 1991, p.vii). In terms of the therapeutic encounter, it has been argued that discourses not only have an immediate effect on clients' abilities to function effectively, but that they also have a more enduring effect on society at large. In particular, both therapists' and clients' discourses that inform psychotherapy have the potential to contribute either to the societal status quo, or to social change.

In examining the discourses concerning psychotherapy, among others one can focus on either the therapists' or clients' points of view. With respect to the present research project, rather than consciously intending to privilege therapists' views, I chose to focus on their perspectives for purely pragmatic reasons, that is time, and availability of research participants.

With the ultimate goal of deconstructing and reconstructing therapists' discourses that inform psychotherapy, the main purposes of the present investigation are threefold: 1) To better understand how psychotherapists make sense of their role in society; 2) To assist psychotherapists in thinking about these issues, and; 3) To incorporate the experiences of real life psychotherapists with the existing literature concerning psychotherapy's impact on society, presented in this chapter. These goals are based on Lather's (1991) attempt at combining critical analysis with social constructionist inquiry (to be discussed at the beginning of the next chapter).

To fulfill the first goal, that is, to expand our knowledge of how psychotherapists make sense of their role in society, I followed Lincoln and Guba's (1985) and Lather's (1991) generic advice, concerning ways by which one can gain in-depth understandings of how people make sense of their world. They suggest that the investigator interact with the subjects of an inquiry in a natural setting, question their constructions, and factor in how their present versions of

reality are shaped by social considerations. Following these recommendations, I interacted with the research participants, using a semi-structured, open-ended interview format. The use of this participatory approach benefitted the participants, while allowing them the opportunity to discuss the issues as they saw fit. Furthermore, the interview guide underwent a number of revisions, as more participants were interviewed. Substantively, the interviews were based on the theoretical model developed in this chapter. Therefore, they focused on therapists' values that get played out in therapy, on the notion that therapists exercise power, on perceived social responsibilities when doing therapy, and on the belief that the non-reflexive nature of the therapeutic enterprise potentially contributes to the societal status quo (details of the interview guide are discussed in Chapter II).

The second goal of this research project is to offer psychotherapists a forum in which they could think about these issues. In the spirit of emancipatory inquiry, this offers both the research participants and psychotherapists who read this report the opportunity to bring potentially preconscious understandings into conscious awareness. This process allows for the possible emergence of "contradictions, distorted or hidden by everyday understandings" (Lather, 1991, p.52). Lather calls this type of awareness 'emancipatory knowledge.' With this knowledge, participants and readers would then be in a better position to critique and reshape their own values and assumptions in a more intentional manner (Thomas, 1993).

However, Lather (1991) also speaks of empowering research participants who are oppressed, to energize them towards action. In the present research, it is arguable that the research participants, already being relatively powerful, are not in need of empowerment (traditionally defined). Therefore, though it is hoped that participation in the project encourages them to develop emancipatory knowledge, an equally important goal is the development of interventionist theory, that possesses evocative power for those who read it.



With respect to the third goal, rather than assuming that the theoretical perspective developed in this chapter is meaningful or useful for potential users, this project attempts to develop a theoretical approach that is informed by the experiences of some of the stakeholders, that is, by real, live psychotherapists. To fulfil this goal, psychotherapists were given the opportunity to contribute to the emergent theory by supplying ideas, some quite theoretical, and some distilled through the nitty gritty of practice. Hopefully,

The result is that (the) theory becomes an expression and elaboration of progressive popular feelings rather than abstract frameworks imposed by intellectuals on the messy complexity of lived experience. (Lather, 1991, p.62)

Throughout this process, though I attempted to 'bracket my preconceptions' as much as possible, it is acknowledged that my understanding of the relationship between clinical psychology and society informed the particular questions that were asked during the interviews and the subsequent analysis. Also, as already stated, this project is informed by Lather's (1991) critical perspective that consciously privileges such issues as power and domination. Therefore, as the project unfolded, I expected these concepts to play some role in the constructions that emerged. However, I did not make any predictions, either as to the way in which these concepts would inform the constructions, nor, more generally, to the actual content of the participants' perspectives. In generating new constructions, the idea was not to find the unattainable truth, but to refine, and to raise even more questions about the issues that are in need of constant exploration.

## CHAPTER II

### METHOD

First I will briefly discuss the theoretical rationale behind the present methodology. Next, I will discuss the composition of the group of research participants, the research methods, and how the data were analyzed.

#### Theoretical Rationale

The paradigm, or world view that informs the methodology, should resonate with the substantive argument if meaningful data are to emerge (Lincoln & Guba, 1985). Substantively, in Chapter I, I argue that the negative consequences of clinical psychology's reliance on logical positivism necessitate the development and implementation of alternative metatheory. Given the criticisms mounted against logical positivism, it would be absurd now to ignore my own advice and privilege logical positivism's points of reference in this research project.<sup>30</sup>

In eschewing positivist informed methodologies, the current investigation is instead based on Lather's (1991) reconceptualization of the relationship between theory and research practices. In using Lather as the theoretical touchstone, this research project also relies on Grounded theory (especially Rennie, 1992; and Rennie, Phillip & Quartaro, 1988), in representing the participants perspectives. The application of Grounded theory is described in the analysis section. At this point, I summarise Lather's (1991) perspective, highlighting the particular aspects of her theory on which this project is based.

Lather (1991) combines elements of social constructionism, feminism, neo-Marxism and post-structuralism that are action oriented. She maintains that research practices should have an interventionist impulse, that they marry theory and practice, that they "contribute to more emancipatory ways of generating knowledge" (p.11).<sup>31</sup> By resonating with people's lived concerns, and by describing how larger issues are embedded in the particulars of everyday

experience, the resultant theories should possess evocative power. That is, they should serve a catalytic and energising role.

Lather (1991) does not advocate research practices that cater to those who have universalizing tendencies and who seek to produce grand social theories. In agreeing with those aspects of the critical social science agenda having an emancipatory intent, Lather positions herself against Marxist hegemony that attempts to control its objects of study, which she argues is widespread within leftist discourses and practices. In reaction to the perceived dangers affiliated with conceptual over-determinism, she favours methodological practices that produce knowledge that is "contested, incessantly perspectival and multiply-sited ... full of unresolvable tensions and necessarily partial" (p.49). She supports practices that speak of, and to, the ever-changing, contextualized experiences of real people. In consciously employing a contradictory, doubled strategy, she privileges issues such as power and domination, while simultaneously emphasizing the agency of the fragmented subject, who is "not single, unified, static nor utterly determined" (p.29).<sup>32</sup>

Lather (1991) endorses critically informed research practices that encourage insights that upset the status quo. She says that such practices should aim at uncovering non-literal meanings that inhere in created texts (Such texts include conversations or interviews). For example, Lather sanctions deconstructionism, that works to reveal the implicit ideological assumptions operating in both the discourses of potential research participants and in the researcher's subsequent re-presentation of these discourses.

Not assuming the possibility of 'disinterested knowledge,' critical research practices such as deconstructionism should allow the researcher to self-referentially decode the ways in which the symbols of culture, that pervade discourse, create asymmetrical power relations. Such practices should allow the researcher to identify ways by which alternative

interpretations of cultural symbols can be displayed.<sup>33</sup> However, according to Lather (1991), such practices

should not position culture as the sole locus for expansion and control ... (That is, one should not) disregard the very real global maldistribution of power and resources. (p.33)

Flexible research practices should be designed to be responsive to the ever changing needs of the 'subject.' They should be praxis oriented, in that they seek emancipatory knowledge. Lather (1991) demands that

an emancipatory critical social science must be premised upon the development of research approaches which empower those involved to change as well as understand the world. (p.3)

The theory emerging from such practices should rely on inter-subjective criteria for judgements concerning their adequacy.

In following Lather's (1991) advice, the present investigation is geared toward developing contextualized knowledge. It incorporates the concerns of real people by building in a number of flexible research practices. In guarding against the charge of over-determinism, the emergent theory accounts for the agency of the research subjects. It is critical in that it privileges issues of domination and power, and in its intent to develop insights that can upset the status quo. It is self-referential in that it takes into account the relationship between the researcher and the research participants.

### Research Participants

I will first talk about the technical procedures used to recruit the sample. Then I will discuss the theoretical issues that guided the sampling process, what I had hoped to gather as a sample and what in fact turned out to be the sample.

The 24 research participants were recruited through the use of opportunistic and snowball sampling techniques (Burgess, 1984). I first selected psychotherapists with whom I

was possible to cooperate (e.g., friends, professional acquaintances, professors, previous supervisors, relatives in the field, etc.). In particular, I drew on contacts that I had made in Toronto, Montreal, Windsor and Detroit. As expected, a chain of informants emerged, as professional acquaintances of these people learned about the study.

To secure the participation of the psychotherapists who I contacted, I emphasized the participatory nature of the process and described possible pay-offs. More particularly, potential participants were asked to participate in a one and a half hour, one-on-one, interview session. They were informed that this session would focus on their therapeutic activities that relate to, and their ideas and opinions about, their relationship with society. They were advised of the interviewer's agenda, that is, they would be asked to furnish background information, as well as to respond to a number of questions concerning psychotherapy's impact on society. However, the format's flexibility was also emphasized, in that research participants were encouraged to discuss the issues that they felt were most relevant, and to digress from the particular questions, as needed. This information is contained in a recruitment statement (Appendix A contains the text of this statement).

At the start of each interview, participants were asked to read a participant information statement, and to sign the attached consent form. These two forms together deal with a number of issues, such as the interview procedure, the identity of the people doing the research, the uses of the data, how to obtain a copy of the research findings, the general issues of anonymity and confidentiality and how they apply in qualitative research (where quotes may be employed), the possibility of the data being published, and the possibility of dropping out of the project (see Appendices B & C).

Certain theoretical concerns were meant to guide the sampling process. For example, I intended to seek out respondents who were in a position to maximize the range of information in order to generate a large number of conceptual categories. This entailed interviewing a

broad cross section of therapists, that is therapists with varied backgrounds and interests. This required that the sample be well represented with respect to such issues as gender, clinical experience, types of training, theoretical approaches in doing therapy, categories of practices (e.g., those who deal with both adults and children, either privately or in institutional settings), social philosophies, and most importantly, theoretical perspectives concerning the issues in question.

In addition, to help insure that the number of categories were maximized, I attempted to follow Guba and Lincoln's (1989) suggested approach in terms of selection strategy. They propose that the sample of respondents be selected serially, that is, new participants are not chosen until after data collection from the preceding participants is already largely accomplished. Second, they suggest that the sample be selected contingently, both in the sense that each succeeding participant is chosen to be as different as possible from preceding ones, and in the sense that participants are chosen in ways that best serve the particular needs of the inquiry at that moment. They suggest that the researcher exploit the snowball sampling technique, by asking participants to recommend other potential participants who have different opinions from themselves.

It proved difficult to carry out some of these suggestions. For most of the participants, I had only vague pre-conceptions about their opinions on this topic. In addition, when I asked for recommendations at the end of each interview for potential candidates who hold different views, the participants almost unanimously said that they did not know what their fellow therapists thought about these issues (an interesting finding, in and of itself). Therefore, for example, I ended up with many of the participants saying that they had an inter-personal bias in therapy and not many saying that their work is predominantly intra-personal.

I was still able to secure relatively broad participation in terms of obvious characteristics (e.g., gender, work settings, etc.). It must be remembered though that

sample selection (was) not based on a desire to make generalizations but to get an understanding of experiences that are both varied and shared through qualitative, detailed cases. (Patton, 1990)

I believe that these criteria were met, though it is possible that a different sample might produce even greater variation than was evidenced in this instance.

By the end of this process, 24 mental health professionals who have all practised psychotherapy were recruited for inclusion in the study. There were 14 men and 10 women. With respect to national origin, 20 were Canadian, 3 were American and 1 was from Pakistan. In terms of religious affiliation, 14 were Christians, 9 were Jews and 1 was Muslim. In addition, 2 of the women identified themselves as lesbians, and 2 of the men identified themselves as gay.

In terms of clinical practice, 18 of the participants identified themselves as clinical psychologists (12 with Ph.D.s, 4 who are practising with their M.A.s outside of the province of Ontario, and 2 who are Ph.D. students in the province of Ontario), 4 as social workers, 1 as a counsellor, and 1 as a psychiatrist. Twenty-two participants are presently practising psychotherapy, with 5 predominantly full time practitioners, 15 part time practitioners, 2 students who are doing some psychotherapy on the side, and 2 who have recently chosen different career paths. Five participants have more than 20 years of clinical experience, 7 have practiced for more than 10 years, 10 have practiced for at least five years, and the remaining 2 participants have between three to five years of experience.

Most of the participants have worked both privately and in an institutional setting. Presently, 5 participants said that their clinical work is primarily private, with the rest working mostly in an institutional setting. Only 2 participants indicated that their work consists almost exclusively of group therapy. The rest said that they do primarily individual therapy, with doing a bit of couples and family work. Fifteen acknowledged that they work primarily with adults, 5

indicated that they work primarily with adolescents or pre-adolescents, and 4 described their practice as mixed.

The demographic characteristics of the participants' clients are quite varied. This is because the participants work in diverse settings, including the downtown core as well as suburban areas, private clinics as well as public settings, community mental health centres, social service agencies, and hospitals. Given this diversity of settings, they are exposed to clients of different backgrounds, in terms of gender, economic and social position, culture, ethnic backgrounds, and presenting complaints.<sup>34</sup>

One participant described his work as being psychoanalytic, 1 said that she does solution-focused therapy, 1 said that he does gestalt work, 2 said that their practice is cognitive behavioural, 1 does reality therapy and 1 said that she does feminist therapy. The vast majority, that is, 17 of the participants, described their therapeutic approach as being eclectic. Of this group, 3 said that their work was predominantly experiential, 1 said gestalt, 1 said cognitive behavioural and 1 said psychoanalytic. To round out the group, 1 participant said that it was impossible for him to label his approach. Given this brief sketch, how broadly representative this particular sample is in terms of therapeutic approaches is open to debate. However, it should be remembered that if there are identifiable differences between the different schools of psychotherapy in terms of values, then it would be impossible to get a 'representative' sample, given the 300-500 different brands of therapy practiced.

Of those participants who discussed their social philosophies or political leanings, 7 described themselves as being on the right of the spectrum (e.g., 1 person described himself as being a capitalist and another (American) said that she was a staunch Republican); 7 said that they lean to the left (e.g., 1 said that he was more liberal/marxist than conservative, and another said that he was a progressive); and 2 positioned themselves staunchly in the middle. With respect to other potentially important philosophical distinctions, 12 participants



volunteered that they are humanists, 2 said that their beliefs were predominantly feminist, and 2 others described themselves as fundamental Christians. In addition, through an examination of the interview transcripts, most of the participants appeared to have had little familiarity with alternative conceptions of power, ideology, and the like.

### Research Methods

Two basic elements were utilized in generating data: the interviews, and the social context within which the interviews took place. Each of these is discussed in turn.

#### Interviews

Each respondent was formally interviewed once. The explicit agenda was to tap into their views concerning the relationship between psychotherapy and the workings of society. Therefore, among other questions, participants were asked to discuss their reasons for becoming therapists; whether they believe that they exercise power; whether they impose their values or their personal sense of morality on their clients; whether they introduce social issues when dealing with certain groups of clients; and whether they view themselves as social change agents, or as agents of emancipation. Most of the questions were drawn from prominent themes in the literature.

In answering these questions, participants were encouraged to talk about their experiences with particular clients, and how these experiences relate to their theoretical beliefs. They were also asked to comment on particularly salient issues that were raised by previous participants.

Due to the emergent nature of the inquiry, the interview guide changed a number of times. The changes reflected some of the concerns and issues raised by previous participants, as well as the ongoing analysis of data. For example, to allay concerns that the study was too

theoretical, a number of hypothetical scenarios were added. Certain questions that were not generating especially pertinent information were dropped (e.g., goals in therapy), while others were added (e.g., whether clients seek therapy for what they perceive to be a social problem) (Appendices D–F contain three sample versions of the interview schedule, including the initial schedule, along with the interview guides that were developed prior to interview number five and interview number nine).

The interviews were tape recorded. The interviewer's relevant thoughts and observations prior, during, and after the interview were also recorded. These recordings were then transcribed. With respect to the question of detail, it is acknowledged that it might have been worthwhile to transcribe every nuance of presentation (e.g., pauses, extended vowels, etc.). However, given limited time and resources, and the belief that it is fetishizing to transcribe these details, I only transcribed the actual words that were uttered. Given this, I believe that the respondents' conceptualisations of the issues were sufficiently captured (also see Hollway, 1989). Following transcription, the original tapes were erased.

After transcribing the second interview, it became clear that returning the unanalyzed transcripts to the participants for their perusal could be beneficial. Not only would this second contact give participants the opportunity (either in writing or in person) to clear up lingering questions I had, but it would also allow them the chance to confirm that the transcribed interview reflected what they indeed wanted to say. When participants requested changes to the transcript, the revised version replaced the original version of the transcript, that was subsequently destroyed.

Underlying some of the changes in the interview process was the wish to provide a context that better facilitated the elicitation of emic constructions, i.e., to allow participants the right to 'name' their world (see Lincoln & Guba, 1985; Oakley, 1981). This allowed research participants the ability to offer their own perspectives, freed from artificial constraints.

Therefore, as the interviews progressed, they became less structured and more open-ended. Participants were given the option of starting the session by generally discussing the issues, freed from the constraints of the interview guide. They were accorded greater latitude to introduce their notions of what they regarded as relevant, instead of exclusively relying on the investigator's notion of relevance.<sup>35</sup>

Some of the participants chose the strict structure of pre-determined questions, while others preferred to speak in a relatively more open-ended fashion. It was not deemed crucial that every participant choose the same option, since the over-riding aim of the interview process was to generate rich data. To give the participants even greater say in framing their responses, a couple of the participants suggested that future participants be given the opportunity to see the interview guide beforehand. This suggestion was not carried out, since we jointly concluded that future participants would more likely furnish 'textbook' responses, that they might be more inclined to artificially create coherence where none existed.<sup>36</sup>

During the interviews themselves, in order to identify salient points needing elaboration, I concentrated on explicating the meaning of the data from the perspective of the participants (Glaser & Strauss, 1967; Guba & Lincoln, 1989; Lincoln & Guba, 1985; Marshall & Rossman, 1989). This process was done in the Dilthian spirit of verstehen.

The verstehen tradition stresses understanding that focuses on the meaning of human behaviour, the context of social interaction, an empathetic understanding based on subjective experience, and the connections between subjective states and behavior. (Patton, 1980, pp.44-45; also see Rickman, 1976)

As I gained some sense of the participants' points of view, I started to rely on critical social science to help me focus on particular processes of the presented material, such as on contradiction, and on paradox, and to help me identify some of the social influences that helped shape the presented discourse. I tried to be conscious of the effects of power and domination on the process of communication. I also became more active, for example asking

more follow-up questions during the interviews, respectfully searching for variation and inconsistencies in the presented discourse (Honey, 1987; Potter & Wetherell, 1987).

### The Social Context

Though the primary data came from individual interviews, this work can be considered 'social' in the sense that the constructions arose in different social contexts, and their enunciation took place in conversation. Therefore, it is conceivable that a number of social factors influenced the formation of offered constructions, including the personal and cultural biases of both, and the relationship between, the researcher and the research participants.

In tapping into these social factors, a number of strategies were employed. The participants were asked a number of background questions, concerning such issues as cultural/ethnic background, approximate age, social philosophy, political affiliations, previous familiarity with issues of domination, power, ideology and the like, psychotherapy training, theoretical approaches in doing therapy, relevant clinical experience, the settings within which they work, and preferred clientele. Rather than presenting these questions in the typical multiple choice format, these questions were asked in an open ended way, to allow the participants to respond as they saw fit.

There were a number of interpersonal processes that were paid attention to during the interviews: e.g., the effects of the interviewer's presence and form of involvement in the interview process, such as "how she or he listens, attends, encourages, interrupts, digresses, initiates topics, and terminates responses" (Mishler, 1986, p. 82); the possibility that ulterior motives were at play; the desire to please; and differences between interviewing strangers compared to dealing with people with whom the researcher has a personal relationship (Potter & Wetherell, 1987; Whyte, 1982). Power dynamics going beyond the immediate context were

also considered as data. Among other things, these were related to experience, knowledge, and professional role.

Arguably, a more 'social' constructionist work would have endeavoured to produce participants' constructions from within a more social context, that is, from within a group setting. However, a number of pragmatic and theoretical reasons underlied the choice for using one-on-one interviews as the primary data gathering instrument. For example, given the challenge of arranging the schedules of busy professionals, it was difficult enough organizing individual interviews. It would have been an organizational nightmare to set up a number of group interviews, especially since the participants lived in different cities. In addition, I hypothesized that richer data would emanate from one-on-one interviews. This belief was due to my feeling that, as a group, the participants could be an especially defensive lot, since many of the participants who lived in the same city would probably already know each other, if not personally, then by reputation. Given the content of the interviews, they might have been more unwilling to criticise their confreres, or to discuss real case examples, with the attendant fears of keeping anonymity. Also, due to my training as a clinical therapist, I felt my skills would be best utilized in individual encounters. In addition, other interviewers have argued that richer material might emanate from one-on-one interviews (Ainsworth, 1993; Hill & Zitney, 1992).

### Analysis

The analysis involved a two-stage process. The first stage, that is the bulk of the analysis, relied primarily on Rennie's (1992) and Rennie et al.'s (1988) version of Grounded theory. It consisted of summarizing and re-presenting the interview material in terms of themes. The second stage, which relied on Lather's (1991) theory, contextualizes these themes in terms of the research process, and relates them to the critique of mainstream

clinical psychology that was presented in Chapter I. This section describes how the first stage of the analysis was carried out. The theoretical rationale underlying the second stage was described at the beginning of this chapter.

The taped interviews were transcribed verbatim. The 24 interviews generated 662 single-spaced pages (an average of 27.58 pages per participant). Then, as Rennie (1992) and Rennie et al. (1988) suggested, these interview data were classified into different levels.<sup>37</sup>

First, meaning units were identified, that are essentially either responses to the interview questions, or particular thoughts concerning major topics. The number of meaning units for all the interviews are 1014 (an average of 42.25 per transcript).

Second, maintaining each participant's meaning units in separate files, these meaning units were condensed into summary statements, usually about two to five lines each. Each summary statement was then labelled, according to categories. Insofar as possible, these category labels were descriptive, reflecting the language used by the participants.

Third, these categories were collapsed into various themes, using an open category procedure. That is, a given category could be assigned to more than one theme. Compared to the category labels, the themes were meant to be less descriptive, and were constructed in an attempt to explain the descriptive categories and the relationships among them. This procedure produced one or two page summaries for each participant. These summaries consisted of the themes and related categories which each participant generated. Overall, this procedure furnished 215 themes across all of the participants, an average of 8.54 themes per participant (the number of unique themes is greater than 8 though much smaller than 215, since most though not all of the themes are shared by a number of participants).

Finally, paying special attention to collective themes or commonalities across most of the cases, the themes were incorporated across participants, into a multi-level scheme of themes. That is, it became clear that some lower order, more concrete themes served as

defining characteristics or properties of other higher order, more abstract themes. In addition, a handful of themes that appeared to have few connections with other themes were either dropped or collapsed into other themes.<sup>38</sup> Thus, a hierarchical arrangement emerged, with three core themes, and nested within them a number of sub-themes, sub sub-themes, etc..

Core themes were chosen based on the belief that they had the most explanatory power. However, in suggesting that these core themes are imbued with explanatory power, it must be emphasized that these explanations are not intended to represent a true state of affairs. I am not championing the existence of real causal links prescribed by Nature. The process of constructing core themes is understood as resulting from a myriad of mutual shapings, and is defended strictly on pragmatic grounds.<sup>39</sup>

The development of these core themes took place in terms of both their internal development and their changing relations to other themes, focusing on their convergence with, and divergence from, each other (Heron, 1988). Critical social science techniques, which simultaneously allow for the adoption of a position while calling it into question, assisted in this process; to reiterate, these techniques helped highlight the contradictions within, the paradoxical nature of, and the negative instances in, the emergent themes. For example, they helped identify and account for the participants' paradoxical understandings of power.<sup>40</sup>

According to Lincoln and Guba (1985), this part of the analysis should have been considered complete only after these core themes officially reached their saturation point, that is, when it was deemed that succeeding respondents would add almost no new pertinent information to these themes. In reality, I had only engaged in the first three levels of analysis while the interviews were still ongoing, and had formally developed the core themes only after finishing the interviews. In an ideal world, that is, if time had permitted, I would have then engaged in a couple more interviews. However, by the end of the last completed interview, I can say with conviction that the lower level themes had reached their saturation point.

Following Patton's (1980) advice, I stopped collecting data, since clear regularities had emerged that felt integrated, given the belief that continuing with the analysis would have overextended it beyond the boundaries of the issues and concerns initially guiding the research project.



## CHAPTER III

### RESULTS

In this chapter, I will present what the participants said in the form of themes that were generated from the interviews. In the next chapter, these themes will be examined in light of Lather's (1991) theory.

The themes are organized hierarchically, with core themes at the top of the conceptual model, and sub-themes, etc., branching down from the core themes. The process of transforming the raw data into this particular schema is based on Rennie's (1992) and Rennie et al.'s (1988) version of Grounded theory (described in Chapter II).

Using this framework, most of the interview material is conceptualised to revolve around two major sets of contradictions or tensions, that is, core theme one, 'therapist-client power relations,' and core theme two, 'whether therapy should and/or has a role to play in the societal context.' In addition, some of the participants make a number of qualifications, asserting that their views are contingent on the professional and cultural contexts in which therapy takes place (core theme three). The content of these core themes, including their analogous sub-themes, etc., are presented sequentially in the order that they are mentioned here.

The decision to feature the contextual nature of therapeutic practice (core theme three) supports the development of contextual knowledge, and is consistent with Lather's (1991) notion that larger issues are embedded in the particulars of everyday experience. The decision to organise the first two core themes around sets of fundamental contradictions or tensions is based on Lather's (1991) suggestion that critical inquiry focus on the progressive elements of participants' current understandings that can manifest themselves in fundamental contradictions, "and which provide entry points for the process of ideology critique" (p.63). There are a number of reasons for choosing these particular tensions. It is partly based on

Lather's suggestion, which is to highlight societal issues having critical import, such as the issue of power and how it is manifested in society. It is partly driven by a key demand characteristic inherent in this study, that is, the participants were all asked to comment on a number of pre-determined topics, some of which are related to the resultant themes. However, the participants not only provide the actual thematic content, but are also instrumental in providing additional topics for inclusion. For example, I planned to explore therapists' power, however the participants (at first unexpectedly), often responded by discussing instead the power of their clients.

It is important to remember that the primary focus of this study is on the themes that emerged during the interviews, and secondarily on the participants who generated them. That is, the study is meant to have evocative power for those who read it, and not necessarily for the participants themselves. Therefore, one may legitimately characterize the following themes as caricatures, in that they represent a number of perspectives, with which no one participant is expected to be in full agreement. In addition, not all of the participants discussed all of these issues, and they were by no means unanimous in their opinions. Where it makes sense, I will make explicit the level of consensus that arose. I will point to variations in how persuasive the core themes, sub-themes, etc., are. However, I beg the reader's indulgence in realizing that some of the nuances can get lost in trying to form somewhat disparate ideas into a relatively cohesive whole.<sup>41</sup>

Following is the presentation of core themes (along with sub-themes, etc.) as outlined above (A taxonomy of all the various themes is presented in hierarchical order in Table 1). To provide evidence that these themes adequately represent the participants' viewpoints, this presentation makes extensive use of quotations, that come directly from the interview protocols.

TABLE 1  
Taxonomy of Themes

**CORE THEME I) THERAPIST-CLIENT POWER RELATIONS**

**Sub-theme A) Client Power**

- 1) Therapy is Client Driven
- 2) Respecting Clients' Choices
- 3) Underlying Ideals

**Sub-theme B) Therapist Power**

- 1) Therapists Have Power
- 2) How Therapists' Power is Exercised
  - a) Therapist as a Role Model
  - b) Therapist as a Communicator of Values

**Sub-theme C) Resolving Power Issues**

- 1) Down-playing the Tension
- 2) Being Conscious of the Paradox

**CORE THEME II) THERAPY IN SOCIETAL CONTEXT**

**Sub-theme A) Relationship is Unproblematic**

- 1) No Need to Question the Relationship
- 2) It's Proper to Uphold Societal Values
- 3) Exclusive Focus on the Individual
  - a) It's What the Client Wants
  - b) It's Less Intrusive and Dangerous
  - c) It's Practical
  - d) It's the Best Way to do Therapy
- 4) Society Benefits Anyway
  - a) Stage that Client is Inner Focused
  - b) Natural Connection Bet. Caring For Self/Others
  - c) Domino Effect

**Sub-theme B) Relationship is Problematic**

- 1) Therapy's Negative Social Effects
- 2) Therapist as Social Change Agent

**Sub-theme C) Common Ground Regarding Therapy and Society**

- 1) Societal Effects Narrowly Defined
- 2) Client Comes First
- 3) Status Quo Practices That Harm Clients

**CORE THEME III) THERAPY IN PROF. AND CULTURAL CONTEXTS**

**Sub-theme A) Facets of Treatment**

- 1) Modality of Treatment
- 2) Length of Treatment
- 3) Client Characteristics

**Sub-theme B) Values in the Work Setting**

**Sub-theme C) Therapist Characteristics**

### I) Therapist–Client Power Relations<sup>42</sup>

Most of the participants consider their clients to be in positions of power, and believe that their own actions in the therapy room accord with that assumption. However, at the same time, many of them are also of the belief that they themselves are powerful and either can or do influence or impose some of their values on their clients. I will first discuss the sub–theme concerning client’s power, and then the sub–theme dealing with therapists’ power. Then I will present the final sub–theme in this section, concerning ways by which the participants believe that they resolve these power issues.

#### A) Client Power

The prevalent belief is that clients have power, meaning that clients can make their own decisions freed from outside constraints, and are responsible for their own actions. Therefore, it is the therapist’s job to follow their clients’ lead, to respect and care for them and help their clients grow. I will now expand on these points. In particular, I will discuss the following sub sub–themes: 1) Therapists’ beliefs that therapy is client driven, 2) Therapists’ beliefs that they should respect their clients’ choices, and 3) The therapists’ ideals which underlie these beliefs.

##### 1) Therapy is Client Driven

In discussing who controls the therapeutic process, most of the participants emphasise the amount of control that they believe their clients do and rightly should assert in the therapy room. Henrietta sums up this position, responding to the question “Do you think that therapists are powerful?” by saying “Only if the clients allow them to. If the client doesn’t want the therapist to have an impact, they won’t” (750).<sup>43</sup>

A popular expression that captures the spirit of this perspective is that therapy is client driven or client centred.

The goals are primarily client driven ... regardless of my particular agenda for a person .... The person makes the real choice about where to go in therapy. (Tony, 1)

Its presumptuous to think that you should know what people want .... Good therapy lets the client define their own purposes. (Michael, 289)

The clients are seen to be driving the process of therapy because they are in the best position to know what is best for themselves.

Penny: The thing is, you see, I feel that people within themselves know what is best for them. I strongly believe that, and that is my philosophy.

Peter: Uh huh.

Penny: And that one of the things, and I make that clear, and it is one of the things that I've been able to stick with. And that is, that I feel that each person, in themselves, knows what is best for them. (Penny, 408)

Participants believe that clients know what is best; therefore, the therapist should not take responsibility for trying to figure out what is best for them. In emphasising this, they stress the belief that clients are and should be responsible for their own actions.

I believe in individual responsibility, I believe that we have a freedom of choice within a limited range, and it is for us (both therapists and clients) to exercise it responsibly. (Karina, 45)

In the end, it is their responsibility of what they want to do with their lives, and how they want to fit in. (Robert, 260)

Many participants encourage their clients to make their own decisions and to take responsibility for their own actions. For example, Mark says:

When patients, say, show a lot of dependency, and ask me to make decisions for them, I usually duck those, as much as I can and try to put it back on them. In a sense, it's communicating to them that I think, in fact, I say it straight out to them, that "I think it's important that you choose your own life and create your own life." (984)

In fact, one participant asserts that only by assuming personal responsibility for one's own life can the client be successful in therapy:

The individuals who take responsibility for their own change ... ultimately can succeed in making the changes that are necessary in their lives. (Myra, 678)

A number of participants maintain that clients can utilize their inner resources to take responsibility for their own actions. Regardless of their social station in life, everyone is seen as having the resources to master their problems and are therefore responsible for overcoming them (Henrietta, 752). Marlene (77) states explicitly that even clients who are on welfare need only to harness their inner resources in order to overcome their psychological problems.

Some participants have clients who take responsibility for themselves within therapy itself. That is, they notice clients exercising their will by making decisions that go contrary to their own (the therapist's) advice. Penny (381) attests to this occurring often, saying that she has clients who make decisions without her approval, that go against her strongly suggested course of action. Some participants are leery of even making any strong suggestions that go against what they perceive to be their client's desires, believing that the client not only can and will ignore the suggestion, but that they might even leave therapy all together as a result.

Imposing values on somebody is not an easy thing to do. They tend not to like it very much and they probably don't tend to stay in the therapy very long.  
(Luke, 201)

The client won't stick around if what they're hearing they don't want to hear.  
(Henrietta, 750)

The belief that clients might drop out of therapy when they perceive that their will is being compromised, impacts on the therapist's choices. For example, Catherine (777) felt herself to be in a damned if you do and damned if you don't quandary, knowing that she risked losing a particular client (as a client) who had threatened suicide, if she even suggested to the client to do something that she knew the client did not want to do, that is, to call 911 if she felt suicidal.

## 2) Respecting Clients' Choices

Therapists understand themselves to be playing a secondary role, that their duty is to follow their clients' lead. Mark says, "I may be able to guide them, but only if they've clearly told me (what they want)" (979). Following up on the 'guide' analogy, Souhail (827) likens his

job to that of a taxi driver, someone who is merely following instructions. The therapist is like the driver who has some experience with the roads but whose only role is to help the passenger reach their chosen destination. Myra takes this position to its logical extreme:

I have very strong beliefs, in that I don't do anything in therapy. That it is the individual that does everything, and it is their choice whether they choose to pick up the tools or not. All that I can do is try to be as clear as I can, to be as safe as I can, for them. To give them and open myself and let them use me. But that it is ultimately their choices, their responsibilities and their decision, and that I am really kind of just there. (Myra, 640)

Almost all of the participants express the belief that they should respect their clients' wishes and comply with their expressed preferences. If the client wants to problem solve, therapists should help them problem solve (Bruce, 370). If the client feels that growth oriented therapy is a waste of time, and instead wants to deal with their immediate, pressing problems, that is what the therapist should do (Michael, 286). Even if the client wants to batter their partner, then at least one therapist says that, theoretically at least, she would support that choice:

Myra: When I look at it from right and wrong, I look at it from the individual's perspective. Is this helping you, is it hurting you, is it getting you what you want, is it not getting you what you want? ...

Peter: Could you imagine ... (that battering) might get them what they want?

Myra: Yeah, I would say so. With some individuals who want strict obedience, or simply want a cardboard individual as a companion. So, I would say, yeah, it gets them what they want, and it gets rid of some of the rage. (Myra, 674)

It is important for the therapist to distinguish between their own goals and the client's goals.

For example, Cleo says

Obviously I would love a person who I found out to be homophobic in therapy, to down the road, some day, to become more enlightened ... But, like, I have to get over it, that that is my goal. (951)

It is the clients' choices which are paramount in therapy:

If it's not what the client wants, if it's not for the benefit of the client, that is (not) my primary responsibility. (Frank, 478)

Participants believe that the therapist should never tell the client what to do, or try to direct the client's process. Therefore, if the therapist wants to present new ideas to the client, the therapist should make sure that the client is on the verge of presenting the idea themselves, that the idea arises out of the session and not from the therapists' ideology. For example, Michael says that it would feel jarring to suggest to a client who has been sexually abused that he or she should lay criminal charges against their assailant:

Just out of nowhere, I wouldn't see that as my role or as appropriate. So, they would be leading me to the edge of that statement before I would feel that it would be a relevant thing to say ... (The idea would have to) arise directly out of the data in the session, rather than out of some ideology on my part. (319,320)

Not to respect a client's wishes and follow their lead is considered oppressive.

One of the things that I had to learn is contracting really clearly with clients, so that, because my agendas might have nothing to do with them .... And that is really oppressive for me, to try to make (therapy) anything larger than they want. (Catherine, 802)

This is especially pertinent since many clients seek therapy precisely as a result of going through an abusive situation. Not to be client-led can imply that the therapist is now putting them through another abusive situation (Josh, 690).

### 3) Underlying Ideals

The conviction that therapists should respect their clients, who are able to make their own decisions and who are responsible for their own actions, is consistent with their underlying belief system. That is, regardless of how they label their therapeutic practice (e.g., psychoanalytically inclined, cognitively oriented, etc.), in terms of general belief system, fully half of the 24 participants are most comfortable labelling themselves as humanists (And given the information being generated in the interviews, my guess is that if asked, the other participants who might not consider themselves primarily as humanists would nevertheless feel comfortable with the label).



A number of participants' comment on their understanding of what it means to be a humanistic therapist. That is, a humanistic therapist believes that people are self determining individuals, who have the ability to change themselves.

In order to work ... as a therapist, I have to believe in the potential of people to change. That is my job. If I'm going to work with someone, I have to believe that they can change. (Mark, 1005)

The humanistic therapist believes that he or she does not have to worry about the direction of the change, since people are understood as being fundamentally good. As Lorraine said, "there are no bad people" (838). Therefore, whatever clients choose is by definition acceptable.

I guess if your value is for people to be self determined individuals, but, within the constraints of not damaging society, then they can choose whatever they want. (Cleo, 950)

From this perspective, the therapist's job is to help them harness their inherent goodness, which is part of everyone's 'true inner self.' The therapist helps clients find their own path, so that they can manifest their inherent potential (Souhail, 808).

Therapy is a journey for the person to really access the core of themselves ... their true inner self. (Penny, 398)

Part of my ideology, is that there is no right ideology, and that my role as a therapist is to help the person find their path, and to travel on their path, to fulfil whatever they want as well as they can. (Josh, 716)

The humanistic therapist believes that people transform themselves through positive, supportive relationships. Therefore, one of the most important powers of psychotherapy lies in the unique ingredients of the psychotherapeutic relationship (Robert, 243; Penny, 603). The uniqueness of this relationship relates to the therapist's ability to be especially "accepting of their clients, supportive and non-judgmental" (Lorraine, 881,888). If the therapist is unable to have positive regard for a particular client, then the therapist would consider telling the client and/or transfer the client to another therapist (Tony, 5-7).

For the humanistic therapist to fully accept their clients' desires, and be able to follow their clients' clearly stated choices, the assumption that they speak a shared language with clients is also needed. Only one participant speaks directly about this issue. Roseanne says that therapists should do what the client wants without interpreting their desires, without reading more into what they say, which she assumes is possible. For example, if the client states that they would have attended a therapy group if only they could had got a baby sitter, the therapist should believe them, and maybe even help them find a baby sitter.

Don't interpret their not getting a baby sitter as whatever [e.g., that they don't want to take responsibility for going to therapy] because that is just a judgement call. Because somebody might interpret that as one way, and then somebody else will interpret it as something else. (Roseanne, 919)

### B) Therapist Power

No matter how much the participants respect and follow their clients' wishes, most of them, at the same time, recognize, to a greater or lesser extent, that they are powerful and that their values play a role in therapy. Given this, I will present the following sub sub-themes: 1) The belief that therapists are imbued with power, and 2) How this power is exercised, that includes the therapist acting as a role model, and as a communicator of values.

#### 1) Therapists Have Power

In discussing the issue of power, one psychoanalytically inclined participant suggests that, "intra-psychic oriented therapists (can be) in general, the most powerful people in the patient's life" (Phillip, 554). This belief, that therapists can be very powerful, is echoed by most of the participants, regardless of therapeutic approach. For example, an eclectic therapist says that therapists "can be very powerful ... and have a major impact in somebody's life" (Alan, 498). A feminist therapist asserts that "therapists are extremely powerful" (Catherine, 767). Likewise, a predominantly cognitively oriented therapist also says: "Therapists are extremely powerful. Extremely powerful" (Bruce, 342).

As stated earlier, it is believed that the key to successful therapy lies in the unique ingredients of the therapeutic relationship. The essence of its uniqueness, that is, its structure, serves as the basis for therapists' power. "Therapists are powerful because the relationship is a power imbalance relationship" (Bruce, 342). Frank describes what this power imbalance means to him:

[Clients] don't get to know about my life. They don't get the ability to, to emotionally hurt me very easily. They can if they want. They can try. But they don't really know much about me, right? So, it's difficult for them to. So see, they become vulnerable, and I don't become as vulnerable .... There are certain ways that a therapist is less vulnerable than a client. So in that way, yeah, in the relationship there is a position of power that's being established. (444)

Partly as a result of this power imbalance, therapists have the prerogative to define the parameters of what happens in therapy.

[The therapist] is structuring a relationship. You're telling them what you find valuable to talk about. (Frank, 436)

I could choose or not, to talk about, to share my values or not. I mean, I'm the one that comes up with that decision. Of course, you always have to keep in mind that you could have a client who might ask. A lot of clients just don't feel that they are entitled to question and challenge and find out ... That is an example of power. (Cleo, 196)

It is possible that clients feel themselves to be somewhat disempowered vis a vis their therapist, and not feel entitled to challenge her/him because they have implicitly agreed to the ground rules in therapy, just by the fact that they are there.

Certainly in the first few sessions ... there is kind of an agreement ... [concerning] the values of, that are going to underlie the relationship. I mean, some of them are very clearly stated in any therapy manual. Like, you are not going to be buddies with the client outside the session. You're going to focus on the client's life, and not yours. You're going to think about, both the inner and outer life of the client. So, there is a certain agreement that isn't very often spelled out that way. (Frank, 437)

Additionally, it is possible that clients accept their one-down position, having bought into the notion that the therapist is the expert, a role imbued with status, that has been legitimized by the state. "Even society portrays him [sic] as the expert" (Bruce, 342).

Having a certain societal status in the eyes of their clients is a pre-requisite for therapists maintaining their power in the therapy relationship. With respect to this issue, none of the participants mention any negative aspects of them being perceived as having status, and therefore, having power. On the contrary, one participant, when asked whether she prefers if her clients did not perceive her as having status and power, says that having status is usually helpful. Having status often helps carry home messages that she makes, and works toward reassuring clients. She also says that:

As a profession [psychologists] are probably more sensitive to these kinds of issues than say, other professions. And so, therefore, it is better for us to have the status because as a profession we are probably more aware of these issues and less likely to misuse them. (Henrietta, 760)

Another participant responds to a similar question, saying:

No. I mean, I haven't thought about it, but, no, it's a reality of the relationship.... No, I wouldn't prefer that they didn't.... Would you want to go to a doctor where he says, "I'm not really an expert" ... They expect you to be the expert. They wouldn't come to you if you weren't an expert. I mean, why would they come to you? (Bruce, 342)

## 2) How Therapists' Power is Exercised

A theoretical link can be made between therapists having power and its manifestation in their practice of therapy. Though not all the participants address how their power underlies their practice, one can make a theoretical connection between their power and at least two practices which many of them do discuss. These two practices are: the therapist acting as a role model, and the therapist acting as a communicator of values. I will now discuss each of these in turn.

### a) Therapist as a Role Model.

At least five of the participants propose that therapists act as role models for their clients, with some of them suggesting this to be a manifestation of therapists' power. They say that clients look up to their therapist, either as a person from whom they learn, whom they want to emulate, or from whom they seek approval.

To elaborate, Souhail said the following:

I feel that therapists enjoy a different kind of power and that is the power of the role model. Patients and their families look up to the therapists and want to learn from them. (813)

It is conceivable that some therapists encourage this process. For example, Francine argues that most therapists (including herself) probably want to be perceived as a role model, and want to use themselves as a guide for what their clients should do. That is, they want their clients to follow in their footsteps, even though that might not necessarily be in their clients' best interests.

Francine: I guess as a therapist you kind of go in with the idea that I know what's right, because it works for me, and of course, that isn't always the case because this other person has come from a very different world. You know, their whole life experiences are different ...

Peter: The idea that the client should be just like you and then they'll be o.k.?

Francine: Yeah, yeah. Because my life is working for me, o.k. You know what I mean? [uh huh] And I realize that isn't a healthy view, and I don't think that actively I sit there and try to convert the person to be the way I am, but I suspect that therapists on the whole kind of feel that my world view is right, and we work with people in that way. (147)

Assuming the mantle of 'role model' can be a powerful tool in therapy. This is evidenced by the fact that gaining their therapist's approval is often very important to the client. "I think that therapists are powerful in terms of giving approval or not" (Lorraine, 884). This is most true with young and or vulnerable clients. As Alan says, with respect to adolescent clients,

Depending on the client, what one suggests to the client, you can make a big difference in their lives, because if they have the approval of, of the therapist, it's in a sense equivalent to approval of a parent, and it could go a long way. (498)

One participant furnishes a specific example of consciously withholding her approval of a client's actions. She describes making a deal with the client, that she would approve of her leaving her marriage only after she

got to a certain point in her own growth and development .... That "once you've [done] a certain amount," and we worked out a deal, "you want to leave your

husband, you want to leave your children, then I'll back you, but not till then, because I think that you're copping out." (Penny, 387)

#### b) Therapist as a Communicator of Values.

When asked directly, almost every one of the participants say that their values play a role in therapy. As one participant boldly states: "I don't believe therapists can be value neutral. I think that is baloney" (Mark, 986). Along with this explicit acknowledgement, at least five participants are of the opinion that the profession as a whole implicitly pretends, both to itself and to its clients, that the therapist can indeed play a neutral role. For example, two of them say:

If you want a general statement, I think that it is a highly value-laden thing that we do, even though we pretend not to. Therapy is one of the great purveyors of whatever values are out there. (Francine, 167)

Values are dripping in the room. They are a pink elephant in the corner that no one is really willing to talk about. (Cleo, 949)

Henrietta says that about ten years ago, when she first started practising therapy, she believed that she could somehow be a neutral observer in the therapy room:

Henrietta: I think, previously I believed that therapy could be more value free.

Peter: When you first started out?

Henrietta: Exactly, yeah. And I think that the longer I practise therapy, the more aware I do become of the fact of how one's values do impact on therapy. (738)

Similarly, until relatively recently Penny also believed that the therapist is supposed to be a neutral observer, "because that is what we have been taught" (390).

Most participants remark on the inevitability of transmitting one's values. For example,

Robert says:

I think it is unavoidable. I think we all do it. We're all embodied theories, if you will, of the world and how the world should be. (256)

It's part of the human condition. Some participants mention that every action a person undertakes is by definition value laden. And in therapy, the therapist must constantly act, choosing what to say, when to say it, etc.. As Randy says:

It is almost impossible not to impose my own values ... You see, there are so many choice points in therapy. I could choose to pay attention to that statement, or I could choose to ignore it. Now, if I choose to pay attention to it, am I imposing a value? (105,109)

Ignoring what others say, and not saying something yourself, is also an action, and is also value laden.

Everybody has a political agenda. If they are not talking about something, they are talking about something. So, it's the same thing. (Catherine, 790)

Many therapists, who believe in the existence of unconscious processes, assume that they are not immune from these processes. Therefore, for example, Bruce assumes that he expresses his values on an unconscious, nonverbal level, often with the client also being unaware that he or she is receiving them at the time. "I'm sure (I communicate my values) because we're human ... We probably deny it though" (388; also see Cleo, 969). Michael also submits that he probably communicates some of his values, which he would prefer to deny:

Peter: Have you had clients who have had goals or stuff they wanted to do that you disagreed with, that you didn't want them to do?

Michael: ... Probably, on some subtle level, where I am not as aware of it, or with some introspection, I suspect I have had that experience, but I kind of defend against that. (290)

Values must come in unconsciously, because we are all human. Another participant says that values also come in consciously, precisely because she is human. She describes a client who had young children, wanting to leave her husband for a man that she had just met.

I'm trying to be as neutral as possible. As a therapist. But I can't leave the human part of me out of it. And part of it is, I mean, do you realize what you're doing? ... I didn't say this directly to her, but realized that a considerable amount had come through anyway. (Penny, 373)

With respect to the choice of values, it did not appear to be an easy task for most of the participants to list the specific values which they convey, either intentionally or not. However, upon reflection, many of them enumerate a number of values which they admit they probably do try to communicate to their clients. In discussing the content of these values, some of the participants talk in quite general terms. For example, Souhail says:

Therapists impart values of health and ill–health to their patients. In my practice I try to focus on emotional issues, trying to help patients and their families to lead happy and healthy lives. (814)

He goes on to equate health with happiness, and with the fulfilment of individual potential (Souhail, 819).

Some of the more particular values which therapists say that they probably communicate include: clients should experience greater freedom of choice, greater self acceptance, greater self awareness (Luke, 197); clients should care about and respect themselves (Lorraine, 835, 843); clients should attain a certain amount of self growth (Penny, 385); and clients should get in touch with their feelings, express themselves and fulfil their potential, or actualize themselves (Mark, 989). In addition, clients should not be accepting of someone else who abuses them, or should not try to gain someone else's obedience (Josh, 706, 707; also Cleo, 938); they should not do violent acts to themselves, i.e., suicide (Myra, 646); and they should not do violent acts to other people, including to their therapist (Mark, 1010). With respect to this last point, that violence is not tolerated, two of the participants say:

If a husband were battering his wife, I would say, "This is unacceptable, and if I'm to continue seeing you in therapy, you're to go for additional treatment." (Penny, 419)

I have worked with a couple, where the father, who is also the husband, was battering the wife. Now, I do take a stand about that. That is wrong. And I'm very clear with them. I believe that that is wrong. If you want to work with me, you need to know that this is how I am going to look at this, that that is wrong. (Randy, 124)

These values are consistent with a liberal–humanist outlook on life, that is, that one should be encouraged to care for and look after oneself, and not do harm to others. As Mark says: "I think that (there) is kind of a humanistic notion underlying (the communication of these) things" (989). It is not surprising that participants, most of whom also describe themselves as humanists, would try to perpetuate humanist values.

Everybody has their own status quo, and the things that they see are normal and healthy, I think they do try to perpetuate what they believe in. (Phillip, 542)



Everybody tries to perpetuate what they believe in. It is impossible to be without politics, regardless of one's values or political beliefs.

Everybody has politics. It's a real misconception to say that because people have traditional politics, those aren't politics, whereas [if] you're left leaning ... then you're a political person [and] you have a political agenda. (Catherine, 790)

Since values have to play a role in therapy, it only makes sense that they should be values in which the participants believe. It is also fortuitous that the particular values in which they believe and communicate to their clients, are precisely those values that are socially sanctioned. In general, the values they list are mainstream values, that help people conform to, and function better within society.

Francine: Therapists on the whole have pretty conforming standards, in terms of society, and that we do try to get those values across, so that people function better within that society ...

Peter: What do you mean by conforming?

Francine: ... The things that help people to get along with others on a day to day basis. It doesn't usually work to go around being nasty to everybody, so you try to work with the person who is perpetually angry, and get rid of some of that. (148)

This does not necessarily mean that therapists intend to communicate conformist values.

Rather, it might be coincidental that their values are consistent with dominant beliefs. As Mark says:

There are some values, more akin to a capitalist society, in my therapy, absolutely, such as free choice, free decisions, assertiveness, individualism. But I don't see that as championing society's values ... Maybe inside each of us there is an ideal society, which is reflected in our values, and we are certainly agents of that. (991,994)

The dilemma arises for therapists who do not hold mainstream values, who feel constrained when they want to communicate values that are considered outside of the norm.

As Francine says:

It's a funny thing, and I'm sure that this is part of what your study is, we're talking values and values. There is a very circumscribed set of values having to do with religious things and that sort of thing, that I hold. And those I'm pretty careful about ... [not] imposing on other people. (143)

On the other hand she feels that it is not only acceptable, but almost obligatory to communicate values associated with 'caring for yourself,' regardless of how that is related to her religious beliefs. In a different way, Phillip also feels constrained in having to follow society's dictates. For example, he expresses a preference to interpret his clients' words as symbolic representations of self but feels that he cannot because societal values dictate that he take their words as representing reality (e.g., he feels he must act if a client threatens murder) (530).

With respect to how therapists' values get communicated, it is usually accomplished through a very subtle process (Penny, 411; Mark, 989). For example, the therapist determines which questions to ask, and often chooses the issues that are in need of interpretation:

We all have a world view which we bring into therapy. And by the questions I choose to ask, the things I choose to follow up on, that those values are all communicated, either very subtly or not so subtly. (Francine, 146)

Phillip: I'm sure that [therapists] interpret many different things, and I want to be more interpretive around those issues.

Peter: Around the issues that are most important to you?

Phillip: Yeah. (Phillip, 99)

Tony furnishes a concrete example of how he would attempt to subtly manipulate a client who holds racist or anti-semitic opinions. He says that he might

gently try to get the person to try to at least explore other attitudes that he can have about these reference groups ... which is an opportunity for subtle manipulation. (9)

Luke also says that he subtly manipulates clients. He likens his work to that of a counter-intelligence agent, in that they both subtly utilize their power in trying to change other people.

Peter: Is therapy an insidious process?

Luke: I think it is. Yeah. Sure it is. Sure it is. You are there acting as an agent of change in another person. That's, that's counter-intelligence, I mean [chuckle]. It's subterfuge ... it is always going to be there, ... there is always this subtle power interplay. As the psychotherapist, I'm always in power no matter what. I always have this subtle power that sometimes even I can't comprehend why it is that this thing is so powerful. (202)

A couple of the participants offer a strategic explanation for not being more forthright when communicating their values. For example, when discussing options with clients, Penny describes how she changes her inflection or expression to subtly communicate her personal preference. If she were more direct, she fears that the client would purposely choose a different option.

In a sense it is part of a game .... Was I being completely honest? No, I wasn't, but I also know that if I am that direct, often the person goes the other way.  
(388)

Likewise, Cleo says that putting the clients' problems into a social context "is something that you have to slowly bring in," once they reach the point at which they are willing to listen to it (958).

### C) Resolving Power Issues

Almost all of the participants offered strategies for managing the tension between respecting clients' power and using their own power. One strategy is by down-playing the tension between the two, in that it might not feel like they are that powerful, or if they have power, then their power diminishes as therapy progresses. Alternatively, many participants say that what they are communicating to their clients does not feel like values, though even if they were conveying them they are values their clients want, and that are in their best interests. Other options, for those times when the tension between the two is unavoidable, include becoming more conscious of their own values and dealing with them by leaving them out of therapy, by getting therapy and or supervision for themselves, or, if neither of these things help, by referring their clients elsewhere. I now discuss these points under the following sub-themes: 1) Down-playing the tension, and 2) Being conscious of the paradox.

### 1) Down-playing the Tension

Many participants, while admitting that they have power, down-played their ability to utilize that power. For example, Francine complains that "a lot of times I don't feel that I can really help people" (180). Bruce also suggests that therapists are not that successful in terms of helping people solve their problems. "You know, we don't take the headache away, we just dull it" (351). By implication, they seem to be questioning how powerful they really are, given their lack of success at helping their clients. In a similar vein, Mark wonders how powerful the profession as a whole is, given his perception that in times of recession, psychology departments in hospitals are one of the first departments to be cut (1014).

One participant says that, even though she theoretically recognizes that she has power, it does not feel like power, because she cannot make her clients do anything.

It doesn't feel like a power over, kind of power. Like the way that one thinks of it mostly, outside, in our society. I'm not making them do things that, just because of me.... I just give them suggestions. (Lorraine, 846)

For this participant, to exercise power means that she is explicitly forcing her clients to do something, without their consent. Likewise, Souhail (a psychiatrist) also says that he is powerful mostly because he can "admit people to the psychiatric hospital against their wishes" (813). (However, he also says that, secondarily, therapists enjoy the power of being a role model [813]).

There are occasions when therapists experience having power. Even though it does not feel like they are explicitly forcing their will on their clients, many participants describe their feeling that clients would do almost anything that they suggest. However, two participants say that this is merely a transient stage in therapy. Clients are presumed to be dependent early on in the process, but as therapy progresses, the clients assume greater responsibility for themselves.

There is usually a stage in the process where they believe everything I say. And then eventually they move away from that and do their own thing ... The

thing that usually happens is that they think that everything you say is great and everything you say is perfect, and they read the books that you read .... But, in the end, it's my experience that most people put their own twist to things. (Lorraine, 837)

I think a lot depends on ... how far they are into therapy. Because there seems to be a point whereby they sort of become more dependent and then will back off. (Alan, 498)

Participants do not perceive a tension between communicating values from a position of power, to clients whom they believe should freely choose their own values, when they do not conceive of the things which they communicate as 'values.' For example, Lorraine does not believe that she is faced with a quandary, since she feels that she is just presenting a value-free analysis of the situation to her clients, and nothing more.

Lorraine: It's weird to me. I wouldn't use the word 'value.' To me, it would be my analysis of how society works. It feels like a different thing to me.

Peter: What is different about it?

Lorraine: My analysis feels different from my values somehow. My analysis is how I think things work. And I would say my values are, what's important. (841)

Similarly, when she suggests that clients should change certain aspects of themselves, she says that it feels like she is talking about their behaviour and not their values.

Part of me doesn't even think about it as a value. It feels more like a behaviour. But it really does come from a value. That that is a worthwhile thing to do. (839)

Other participants also expressed forgetting that what they sometimes communicate to their clients are indeed values.

Peter: Does it feel to you that you are imposing that value [for them to make their own choices] on them?

Mark: No, it doesn't feel when I'm doing it, because I think, um, it doesn't feel like I'm trying to impose anything. But it is just something I believe. It's sort of just woven into the fabric of how I work. (985)

Francine says that when she helps clients become more selfish, it somehow feels value-free "because it's what they want to hear" (166). A number of participants suggest variations on the theme that they are not unduly manifesting their power, since they are only

doing what the client wants. For example, Roseanne deals with the paradox of empowerment through imposition, by only empowering clients who want it:

Some people don't want any power in their lives, and some people maybe want, choose to be depressed .... I certainly don't try to tell these people that they should have power over their lives. But, if they tell me they want more control, then I will try to help them. (918)

More generally, Souhail says that he has learned a lot of what he does in therapy from his clients, including the value that therapy should be growth oriented (809). Penny says that part of the social analysis that she uses in therapy is not consistent with the psychodynamic model which she learned in school, but was learned from her clients instead (396). Martin says that the values that inhere in his therapy are the result of a collaborative effort:

They have actually evolved with my clients. It's hard to tell what begins with me and what begins with those I learn with. It's a gradual awareness that we've come to. (590)

And finally, Lorraine describes a relatively unique situation, in that her clients interview a number of therapists prior to starting therapy and choose a therapist who has similar values. As a result, Lorraine is almost assured of doing what her clients want, because there is an almost guaranteed match between her values and her clients' values.

It is sort of a self selecting thing .... The type of way that I get clients often is through a process where people come and they interview you, and they ask you a thousand different questions, to see if they are going to match. So, they are looking for a match before they start, and it just isn't my experience that I don't usually click with somebody if our values are totally different. (Lorraine, 836)

Therapists believe that they communicate values which their clients want to hear.

Substantively, these are values that are in clients' best interests since they are congruent with respecting clients' wishes. For example, telling clients "to decide things for themselves (and) ... not to pursue something just because some authority figure tells them that is what you are supposed to do" (Josh, 703), safeguards therapists from the charge of imposing their will on their clients.

## 2) Being Conscious of the Paradox

Some participants say that there is a tension between their own power and respecting their clients' power. Randy characterises it as the classic paradox of exercising power by trying to give someone else power (127). Luke says that there is an inherent paradox in trying to change people through accepting them (233). And Phillip discusses it in terms of the tension between the therapist being influential, and the client being responsible at the same time (555).

Without offering any concrete suggestions, Phillip says that it is incumbent to contemplate the paradox.

It is something that has to be contemplated. But I think that both are true. I think that therapists are very powerful and I think that patients are responsible for themselves. And, I think that it is possible to have both, even though it's difficult to understand. But, actually, this is what I believe. (555)

Other participants propose more concrete ways for dealing with the paradox. Their proposals stem from a concern that therapists might misuse their power, thereby infringing on their clients' power.

[The therapist has] powerful and effective techniques, and [if] not used wisely or judiciously or sensitively, then people could end up being harmed. (Karina, 61)

For example, therapists can infringe on their clients' power by projecting their personality on their clients, in essence trying to convert them so that they take up their therapists' causes (Frank, 473; Henrietta, 737; Phillip, 569).

One suggested course of action that therapists can take to guard against the misuse of power is to become more conscious of their own power.

I tend to down-play [my power] at times. And I think that that is a real mistake,. Because that is when you start abusing the power, is when you start believing you don't have it. (Luke, 203)

If we pretend that we don't [have power] then we are going to get into more trouble than if we say yes, we do have power. Because we have power we have to be very careful about how we treat people. (Randy, 128)

By acknowledging their own power, therapists put themselves in a position to keep their values out of therapy, as far as is humanly possible. By being vigilant, they minimize the impact that their values have on their clients (Josh, 702; Michael, 303).

Other participants discuss what therapists should do if they find it difficult either to recognise how their values are impacting on therapy, or to minimise its impact once identified. They say it is incumbent on them either to seek therapy or supervision for themselves (Penny, 423; Phillip, 569). After having done this, if they still find it difficult to leave their values out of therapy, they suggest a number of options. One, they can refer their clients elsewhere. For example, Mark values the exploration of feelings, considering it critical to doing good therapy. However, he realizes that for some ethnic groups, showing emotion is unacceptable. With such clients, he "very nicely tries to refer them to somebody who is able to work with that" (1000). Josh does not accept the goal of clients who want to be more accepting of someone else abusing them, would tell them this, and would refer them elsewhere (706). Alternatively, therapists can reveal their values to clients, while saying clearly that they are merely values and not truths (Catherine, 768; Luke, 227). This then leaves it up to the client to decide what they want to do. Josh discusses this issue in some detail:

Someone comes in, and I will be clear with them that my religious perspective is different from theirs and they may not want to work with me. I will be clear with them.... The right path for me might be different than the right path for them. There are no absolute answers, or absolutely correct paths ... I'm pretty direct with clients. Well, I think I tell clients in major issues of value and ideology, when my view differs from their's and then I leave it up to them. (717)

This latter option, suggesting to clients that the therapist is not an expert who has the answers, also serves the secondary purpose of empowering the client: -

How I would function as a therapist, at my best, was to allow people to understand that I really, I don't have any answers, I don't have any cures, that it is all a process. And, that as such, that shifts the power, right away .... (Catherine, 770)



## II) Therapy in Societal Context

Most participants take one of two positions in conceptualising the relationship between therapy and the societal context in which therapy takes place. Sub-theme one, 'the more prevalent position,' is that the relationship between therapy and society is unproblematic, and is a non-issue. Sub-theme two, 'the less prevalent position,' is that therapists focus too much on the individual.<sup>44</sup> This latter position prefers a more pro-active stance in trying to benefit society. In addition, a third sub-theme, that is held by almost every participant, deals with the overlap between the more and the less prevalent positions. I will now discuss each of these sub-themes.

### A) Relationship is Unproblematic

The more prevalent position is that it is unimportant to spend time questioning therapy's relationship to society. Most of the participants are comfortable with the notion that therapy upholds certain societal values, such as individualism. They express their feeling that therapy should focus exclusively on the individual. They also assume that society spontaneously benefits as a result of their individual focus, since they presume that people are naturally good.

Within this position, I now discuss the following sub-themes: 1) There is no need to question the relationship, 2) It's proper to uphold social values, 3) Exclusive focus on the individual, and 4) Society benefits anyway.

#### 1) No Need to Question the Relationship

A predominant response is that, prior to the interviews, most of the participants had not spent a great deal of time thinking about the impact of therapy on society. Francine and Roseanne both sum up this general attitude.

I really think of my work as a therapist in terms of the individual ... In general, I don't think in those broad terms. I realise that I suppose what we do does have

broader implications, but I don't usually think in that frame of reference. (Francine, 181, 182)

Maybe we do perpetuate that whole individualism, of capitalism. But I haven't given it that much thought, to tell you the truth. I'm not concerned with that. I should tell you that. (Roseanne, 913)

It is possible that many of the participants have little motivation to consider issues that extend beyond the immediate concerns of their clients, given the general belief that they are not powerful enough to effect radical change in their clients, let alone on society at large (Mark, 996; also see previous discussion on therapists' power).

Assuming the opposite, that therapists have a societal impact, does not necessarily mean that they would then spend more time reflecting on these issues. As one participant suggests, there is an inherent difficulty for any therapist to sustain a broader perspective, given the psychological impact of working day after day, with one individual client at a time.

When you're lost in the forest, and you're working at the individual level long enough, on a Thursday afternoon, you might not appreciate [the societal effect you could have]. (Cleo, 954)

Cleo goes on to say that, if anything, this study probably over-represents the number of psychotherapists who think seriously about these issues. He is of the opinion that therapists who do not pay any attention to power issues probably chose not to participate in this project, because they would have nothing to say (Cleo, 955).

## 2) It's Proper to Uphold Societal Values

Though most of the participants believe that they do not possess the power to change society (let alone their individual clients), they concede the theoretical possibility that their work is consistent with the maintenance of the societal status quo. As Luke comments, on the difference between using the power of therapy as a mechanism of change and as a mechanism for maintaining the status quo: "It's much easier to keep things the same than it is to change them" (218).

Many participants perceive little benefit in further analyzing this acknowledged hypothetical relationship between therapy and the social order. This is because they not only accept, but are comfortable with the supposed role which therapy plays within the socio-political context. This acceptance is most pronounced when it comes to valuing the individual. They accept the implication that, theoretically, therapy helps maintain this social value, that arguably is one of society's central tenets.

Specifically, Francine says that therapists have conforming standards, in that a key goal of therapy is to help people function effectively in society (148). Alan is even more explicit, providing details for what it means to help clients conform:

Part of my goal was to help these kids become taxpayers, eventually to go out and work and get a job .... Although I wanted these kids to be taxpayers, it's in the sense that they would be productive citizens. (496)

Karina focuses on the concept of individual responsibility in describing her understanding of therapy's conformist role:

I agree that (therapy) is embedded within the socio-political context, and to the degree that it values the individual, and individual responsibility, it certainly reflects the cultural and political milieu. (44)

In putting forth this formulation, Karina represents most of the participants, in her willingness to help perpetuate these values.

I believe in individual responsibility ... I don't think I would be comfortable in a more communal, in a less individualistic sense of the word, where our identities were more social than individual. (45; also see previous discussion concerning the idea that clients should be responsible for their own actions)

Even if therapists endorse different values, Ross argues that it would be devastating, irresponsible and disrespectful not to perpetuate the values pertaining to individualism, because that is what clients expect, because "that is the way our culture works" (610). That therapists should endorse individualism is also considered an outgrowth of their primary responsibility, that is, to respect their individual client and his or her choices. This obligation is

blinding, even if it implicates the therapist in supporting certain institutional structures that are causative of the client's distress. As Tony says:

Certainly, if I'm seeing people who are part of any institution, let us say, a factory or a hospital, and I'm helping them deal with their stress, and helping them cope better with their jobs, I am doing two things at the same time. One, I am trying to help them with whatever it is that they said their issue is, but I am also supporting the system which is keeping them stressed. I am not saying to them, "why don't you just get out ... People shouldn't work in hospitals, or factories. Of course you're stressed. It's ridiculous." So I think there is that side to it. (21)

Finally, Bruce puts his own realistic spin on this issue. He remarks that if therapists do not endorse conformist values, they would be defeating themselves in the long run:

We exist because society allows us ... mandates us to exist... I think society is structured in such a way that you need doctors and you need therapists. And the structure makes it, allows us to exist ... Obviously we're maintaining the social structure, otherwise we wouldn't exist. They would get rid of us. (367)

### 3) Exclusive Focus on the Individual

A number of participants clearly state that they should concentrate exclusively on helping their individual clients, regardless of the effects their work might have on society. For example, Bruce proclaims: "Therapists (should) help a client solve his [sic] problem, not solve society's problems" (356). Mark and Josh echo these remarks:

Our priorities should be to the patients that we serve, not to society. (Mark, 1003)

The clients' interests take precedence over society's interests. I think that is my responsibility, to the client. (Josh, 711)

The proposal, that once therapists discharge their primary responsibility to their client, they should then be responsible to society at large, is rejected. As Mark says, "I don't see my role in any way as trying to help the world" (1006). Roseanne says that she does not feel compelled to help the client to better society (921). Similarly, Josh says that, if he deems it beneficial to the client, he might suggest to the client to do something that is also in society's

interest. However, "I certainly don't feel I have a social obligation to make that suggestion" (714).

A number of participants acknowledge that psychologists in general have certain social obligations. However, they also remark that the Canadian Psychological Association's code of ethics says nothing about therapists having any special social responsibilities (Alan, 518; Josh, 725). Both Phillip's (566) and Bruce's (349) declaration that therapists have no special responsibilities to disadvantaged groups in society, is consistent with this general belief.

A number of reasons for therapy's exclusive focus on the individual are offered. These reasons can be categorised as follows: 1) It's what the client wants, 2) It's less intrusive and dangerous 3) It's practical, and 4) It's the best way to do therapy. I now discuss each of these in turn.

a) It's What the Client Wants.

To reiterate, therapists who subscribe to the liberal-humanistic perspective believe that their clients, who are capable of making their own decisions, should be the driving force behind the therapeutic process. Therefore, if clients want to talk about themselves and focus the therapy on how they could best take care of themselves, then that is what should happen. As Ross says:

A lot of people go into therapy expecting that, and hoping for that ... [which I help them with, due to] my respect for that person. (626)

The therapist should be wary of putting the clients' problems into a social context if that is not what they want (Cleo, 958). For example, Luke says that he rarely analyses the relationship between clients' issues and the larger systems that might be impacting on them, because it is not what they want, and it is not where they focus their energy:

Luke: If somebody says, "Ah, I'm having such a hard time finding a relationship which is right for me." What's in your face is what this person is struggling with in terms of their own lifestyle. What's not in your face is that that is interacting with the media that says, "this is the kind of relationship you must have." That's a step removed and it would be very interesting to bring that forward, but

typically, the energy isn't there ... If I say to somebody, "Have you ever thought about how your relationships with your parents impact on this?" they will say, "Oh yeah!" That's internal, that's real, that's right there. But if you say, "Have you ever thought about how, you know, Leave it to Beaver impacts on you?" they go, "what?" I don't think that people tend to walk into our offices with this larger perspective of society, and how they fit in to it.

Peter: So, this larger stuff isn't in your face?

Luke: Yeah, it isn't in THEIR face and therefore it isn't in mine. I really, I don't tend to, I'm interested in it, but I don't tend to focus on it in therapy. (194)

In other words, since clients resonate more to their immediate experience, therapists should spend more time and energy talking about their clients' immediate relationships and memories than about societal issues (Michael, 297).

#### b) It's Less Intrusive and Dangerous.

It feels less intrusive to focus on the individual than it does to take a societal approach. Making this distinction explains Penny's comfort in discussing her beliefs about intra-personal functioning with a client who was involved in an extra-marital affair. That is, she feels that it is acceptable to tell the client that

You're trying to find the type of fulfilment, through someone, that you ought to be looking for within yourself, and creating for yourself. (383)

At the same time, it accounts for Michael's remark, that therapy is not the place to discuss his beliefs about how the oppressive system is damaging people, because he believes that it is intrusive to be "peddling a philosophy or a political view" (307).

Others go further, saying that there is a real authoritarian aspect to teaching people one's ideological perspective about how society works (Josh, 699). Josh goes on to say that

it's dangerous ... for a therapist to define for clients what is in society's interests, ... (because) the therapist (could) see the client as a tool to be used to carry out the therapist's ideology. (714)

Karina says that it is a disservice to clients to comment on their external environment. This is due to the fact that therapists must be assuming some kind of omniscience, since they do not have direct access to their clients' external reality (36). Similarly, Luke says that therapists should keep their ideas concerning societal functioning out of therapy (216), and Tony asserts

that if therapists desire societal change, they should try to fulfil their goals outside the therapy room (22).

c) It's Practical.

Participants mention a number of pragmatic reasons for focusing therapy on their clients' immediate concerns. One of these reasons relates to the question of time. That is, with most clients, therapists have a limited time frame within which they can work. Illustrative of this is Frank's comments concerning the impracticalities of focusing on the more general level, when he sees most of his clients for only a couple of months (449). Francine also invokes the 'time' argument, saying that the need for expedient communication with other mental health care workers in institutional settings makes it impractical to think and work in sociological terms. She asserts that,

Being in this system, it's partly a matter of time .... They are not in here very long, so you go with the most expedient way of communicating about them. For example, this person has a borderline personality ... (Francine, 154)

Another factor is perceived resources. Some participants perceive that "intra-psychic processes is all that (they) have to work with" (Marlene, 75). Broader societal effects are not considered reliable resources, that is, using interpretations that are based on societal considerations are not considered to be reliably helpful to clients. Given the belief that not everyone is affected in the same way by society, therapists can only count on an intra-psychic analysis. An example is Phillip's assertion that he would focus on a woman client's relationship with her parents in the case of incest. He says that in such a situation, he would not raise the more general issue of a woman's place in society, since there are a number of women who are not affected by the broader social forces in the same way (539).

Even if the therapist prefers to offer an in-depth social analysis, the client might not be ready for it, something that is especially true for most children (Catherine, 803). Looking at the issue from a different angle, it might be in a therapist's interest to ignore the social aspect of

his or her clients' behaviour. That is, to maintain an empathetic and supportive stance with clients who are not considered to be tolerable people, it might be necessary to block out the effects that their behaviour has on others (Henrietta, 746).

d) It's the Best Way To Do Therapy.

Josh says that it is inherently harmful to make bettering society as a co-equal responsibility to helping the client because "one of the most important powers of the therapy is that the client's interests are always paramount with a limited set of exceptions" (724). He goes on to say that this does not mean that it is wrong to bring in social issues but that it is wrong to feel that one has to bring them in, because that inherently detracts from the relationship.

Not only do participants feel that the best way to do therapy is to focus primarily on the needs of their individual clients; they also feel that their clients will be more successful if they also focus on themselves. As Alan says: "People seem to run into trouble when they try to please others and don't look after their own needs" (509).

4) Society Benefits Anyway

Though it is not a goal, a number of participants believe that therapy has a positive impact on society. If clients appear to be self absorbed, it is considered to be merely a transient stage in the therapeutic process. Once clients start caring for themselves, it is assumed that they will start to care about others. Eventually, therapists believe that a domino effect, leading to improvements in the client's social world, naturally occurs. These beliefs are consistent with the liberal-humanistic assumption that people are good, and that therapists need only allow people's tendency to do good to unfold naturally.

I will now discuss each of these sub sub-themes: 1) Stage that client is inner focused, 2) Caring for self and others is naturally connected, and 3) The domino effect.



a) Stage That Client is Inner Focused.

A couple of participants are acquainted with the charge that therapy encourages people to be self-absorbed. For example, Penny knows of James Hillman, who she says wrote that therapy clients have a tendency to become focused on themselves and not on the larger world (403). Lorraine says that she has heard this argument first hand:

Lorraine: I hear that complaint a lot, from people about, that they don't want to deal with people, their friends, who are in therapy.

Peter: You hear this from whom?

Lorraine: Well, I hear lots of clients are angry at their friends, because they have become really self centred, because they have gone into therapy. (861)

Though only some of the participants express previous knowledge of the charge, they are almost unanimous in refuting it. Martin's response is prototypical of their reaction. He says that he does not recall experiencing having clients who became more self centred over the course of therapy (585).

At most, participants admit that some clients go through a transient stage where they are self absorbed. For example, Martin says that

There might be adjustment phases, periods where the person's needs seem to increase, take priority temporarily. (However) then it gets reworked, until there is more of a balance between the needs of others and the needs of themselves ... I really think that it's a natural progression of a safe therapeutic process. (578)

Similarly, Penny says that being inner focused is part of the therapeutic journey:

But as they start coming out of that, their expansion of the world increases ... Initially there is the constriction in terms of self interest. But then I've seen the expansion take place. (403,405)

A few reasons are offered to account for the initial self absorption stage in therapy. For example, Alan suggests that only after working intently on one's own needs would a client be in a position to understand that he or she needs other people. He describes this process as being one of 'course correction.'

I find that, therapy with certain individuals at a certain time, early in therapy, encourages the person to be very concerned about themselves, and others

tend to interpret that as being selfish. Um, and I think that is a question of course correction ... meaning if one is driving a car and one wants to swerve to avoid an obstacle, one tends to move out a bit too far and then come back to the centre of the road. I think part of what one can get out of therapy, and what I mean by that is looking into themselves, and seeing what their needs are, is that, they probably do need other people. That they are not completely isolated and on their own, and they enjoy other people, because that seems to be the human species in general. We have tended to co-habitate and move together. That is what we do. So, I don't see any perpetuation of individualisation. (527)

Lorraine offers another reason. She talks about a number of her clients who are social activists. She describes how they become more inner focused during therapy's initial stages, since they are too burned out to care about others. However, as therapy progresses, she describes noticing that they do less socially active things than they were originally doing, but that they are more engaged in the ones that they do do (891). Finally, Henrietta conceptualises her clients in terms of stages of moral development. As they progress through different stages, she says that they become more outward focused (742).

If one thinks in terms of stages of moral development, then it is conceivable that the stage where the client is inner focused can be quite long. Even if one does not subscribe to such a stage theory, the transient period where the client is inner focused can still last for an extended period of time. As Josh says, some clients are not ready to deal with very painful stuff, so they might not explore the impact that they have on others until maybe five to ten years later, when they resume therapy. He declares: "I'm saying that I think it may be intrinsic to the process, that some people need to deal with different things at different points in their lives" (693).

#### b) Natural Connection Between Caring for Self/Others.

People want to care both about themselves and about others. The latter need is as much a part of the human condition as is the former need. "The more fully human someone becomes, the more likely they are to have something to offer other people" (Josh, 700). The two needs, to care for oneself and for others, are believed to be inextricably connected. In

suggesting that one is a prerequisite for the other, Michael says, "Taking good care of yourself is a way of deepening relationships with others. It is not an either or proposition" (294). It is Josh's experience that people do not feel good about themselves when they exploit others. And when people feel good about themselves, they act differently towards other people. They realize the way they treat others impacts on them and their quality of life (Josh, 692,723).

A couple of participants argue that in order to achieve a basic goal in therapy, that is, to experience self esteem, one must care about others. They suggest that, by definition, one cannot feel authentic self esteem if one treats others poorly. They testify that improvement in their clients' self esteem has resulted in more harmonious relationships with their external environment (Martin, 578; Robert, 260).

Clients come to these understandings naturally, by themselves:

I think people really ultimately come to the same kind of harmonious integration [of their own needs and the needs of others] that I would want them to. But I don't see it as a result of my influence. I don't direct it. (Martin, 579)

Similarly Michael says that he does not impose the values of caring for oneself and for others, because these are universal values that almost all clients already have (295). Therefore, the therapist's job is not to instill, but rather, to help cultivate these pre-existing values.

### c) Domino Effect.

There is a widespread belief among participants that individual therapy has a ripple effect. They generally assume that, as individual clients change, then so does society. However, there are different theories concerning the machinations of this assumed domino effect, that is, of how individual therapy bestows benefits on society. For example, Karina and Lorraine both express relatively clear, though different, conceptions of how this process works. Karina says that "given the right conditions, people will emerge from therapy more generous, more open, more creative, that it kind of reverberates from there" (39). Lorraine says that her clients gain a better understanding of the world around them, that can lead to societal change

(873). On the other hand, Robert says that he has no clue how the effects of therapy generalise. He says that what happens in therapy

generalises in some way, in a mysterious way, to outside, that it reverberates when it goes out, into society, and whatever that means, to have an impact. (281)

Regardless of how exactly individual change generalises to the societal level, most of the participants are certain that they have little to do with it. Instead, it is considered a natural effect of doing good therapy (Phillip, 563). As Henrietta says:

If we are doing good therapy, we can't help but affect the world in becoming a better place. It is just a natural consequence. Because, as we are able to help one individual grow to the point where they can be better parents, better siblings, better people, we can't help but effect it. (753)

Therefore, since they have little to do with it, therapists do not concern themselves with it.

I certainly think that if they better themselves, or if they feel better themselves, they are going to benefit society, so I don't worry too much about society. (Roseanne, 921)

There is some disagreement concerning the scope or importance of this effect. For example, the previous quotes indicate the possibility that the effects on society are substantial. On the other hand, Frank, though he agrees that the effects of therapy probably reverberate to the client's immediate environment (i.e., family, school environment), is more uncertain of how much larger the influence could be (475). Michael is more sure that whatever larger effects therapy could have, they are not momentous: "I don't have any illusion that it is going to revolutionize the world. It is a pretty small piece of the puzzle" (300). Catherine is ambivalent about the whole issue. She says:

If you change the individual components, possibly the whole does change. On another level, if there is a continuing revolving door of individuals, so you might help some, but there is going to be twelve on the other end, coming in, then there is no social change, possibly. But maybe, if some of them leave, and they're better equipped, and they go out, and they work on the social change, maybe some of it starts to dismantle. (Catherine, 795)

Finally, Phillip alludes to the possibility that therapy plays a revolutionary role. For example, he fantasises what the world would be like if only Hitler had been in therapy. He believes that if this would have happened, then Hitler might not have acted out on society, since he would have attained the understanding that he hated Jews because he believed that his grandfather's Jewish blood poisoned his beloved mother. More generally, Phillip says:

When people learn something about themselves, when they become aware, they become more interested in finding out what else is going on with them (thereby become less angry at external triggers). (563)

### B) Relationship is Problematic

A minority of participants ('the less prevalent position') point to undesirable social conditions, partially resulting from the way in which most therapists practice therapy. They mention that the most prevalent of the therapeutic practices that make a negative contribution to society is the almost exclusive focus on the individual client. In order to combat the negative effects associated with these individualizing tendencies, these participants, while realizing the difficulties inherent in the suggestion, advise that therapists should be more proactive agents of social change. They suggest a number of ways to accomplish this task, including the use of a socially based analysis in therapy.

I will now discuss these sub sub-themes, which are: 1) Therapy's negative social effects, and 2) Using therapy to change society.

#### 1) Therapy's Negative Social Effects

As already documented, most of the participants restrict their energies to helping their individual clients solve their immediate problems. Some participants claim that this almost exclusive focus on the individual's well being leads to a number of problems that have societal wide ramifications.

For example, Francine expresses the belief that psychology's individual focus is related to the fact that people in general are becoming more selfish. She says:

There is a kind of self centredness that I think is kind of pushed by psychology as a whole ... this whole notion of intense self focus, and getting yourself ahead, and whatever is right for you is okay and forget the rest of the world ... Some of that is useful, but a real self concern, self focus ... has always really bothered me. (162)

Ross also alludes to this same danger, that is, of therapy breeding selfishness. He relates this effect to a particular value which he regards as being inherent in psychotherapy, that is, the value associated with talking. While declaring that it is a laudable value, he expresses the feeling that therapists push it a little too much, that they help foster what he terms 'the culture of complaint.' Now, "everybody wants to be heard, and no one is listening" (607).

In a related vein, Ross also says that psychotherapy represents telling a stranger one's woes, that helps maintain what he calls 'a culture of strangers.' He expresses the wish that our culture move away from this trend, that people become less individualistic and less alienated from each other (610). Lorraine provides a specific example of how psychotherapy contributes to 'the culture of stranger' syndrome. She expresses the belief that therapy has inhibited the development of the lesbian community, based on her observation that members of this particular community go to their therapists when they have issues to discuss, instead of talking to each other (865).

On another level, Luke discusses his concern that therapists, by focusing on the individual, are absolving society of its legitimate responsibility for peoples' problems. For example, he says that therapists who act as if the client's problems stem from early childhood years, completely eliminate any social influence (229). Similarly, Frank confesses that he might inadvertently be giving the impression to his clients that they are somehow damaged, and that society is not (458). He says:

Frank: That again confuses me, or at least that I'm still grappling with. You say to the client, part of the time, you say, "Yeah, what a depressing world." So, yeah, part of your message is, it is a depressing world.

Peter: And that they're depressed because of the depressing world?

Frank: Uh huh. And then, but you're only seeing the individual. Are you out there trying to change the world? No. So then the other half of the message is, "but it's you. Other people aren't depressed in this depressing world, so you are also somehow at fault here." So, you know, I think in my mind there are two messages being sent out there, and in my mind that is why, I have to think about this more and more and more because I'm confused. (455)

This is comparable to the situation which Catherine says that she faces in therapy, of helping people become happy in what she considers to be an unhappy world:

I'm sort of scared of that notion, of people finding happiness in therapy. I think that that, when you talk about the status quo and all of that, that that is a trap. I don't think that it is a real happy place, the world. So, finding happiness for people, I don't know. (801)

Catherine goes on to say that therapy, by overemphasizing the individual basis of people's problems, and by underemphasizing the societal components, can lead to de-politicization.

She said:

That is a route to de-politicization. You know, if everybody feels that it is their own individual pathology, then politically, you can't really form commonalities to move forward. (766)

However, Catherine also says that there are no easy answers as to what to do:

It's important to alleviate people's pain, or to allow them to function effectively, with a lower degree of anxiety. On the other hand, in terms of what it does, in terms of perpetuating the status quo, is a real good question. And I don't know. (767)

She says that this dilemma is further complicated by the possibility that the therapist, in empathising closely with the client's perspective, can start to lose sense of what is right or wrong for others, in the so-called 'real' world (775).

## 2) Therapist as Social Change Agent

The less prevalent position holds that, while helping the individual client, therapists should also actively contribute to society. For example, Penny asserts that therapists have an obligation to act as agents of social change, to make the world a better place in which to live

(414). Robert says that it is not only appropriate to try to make the world a better place, but that it is incumbent on the therapist to do so (251). Catherine, in saying the same thing, asks rhetorically, "why else would you be doing therapy, if not to make the world a better place?" (789).

A few participants say that therapists should employ relatively direct methods in trying to effect social change. Among the more explicit expressions of the need for direct methods is Robert's declaration:

[Therapists are] obligated to exercise [their] authority in a proper, direct way, to alleviate the conditions of the world. (274)

One direct way, which both Robert and Luke suggest, is to use the power of psychotherapy to help the most disadvantaged groups in society (Luke, 205; Robert, 274). Catherine argues that there is also a political basis underlying the choice not to see disadvantaged people, the people who are those most in need of help. She says:

Where I live, it is extremely hard to get psychiatrists and psychologists to take people who have been in psychiatric institutions ... [which is] the catch all place for poor people who aren't happy ... There is no hierarchy of pain and need. If anything, it's the people who are at the bottom, who are acting out, who are most difficult ... who need it most. (778)

Other relatively direct methods include helping clients influence institutional systems. For example, Randy says that she advocates on behalf of her clients, to help them better affect systems with which they have encountered problems (111, 113). Roseanne also advocates on behalf of her clients, helping them get heard when they have good complaints, telling them that they are not powerless, and encouraging them to do things like writing letters to the editor (915). As she says:

It's rather ridiculous to try to show them what happened to them in the past and send them back into the same environment and expect them to get well. I mean, if I could, I would change their environment. I try to change a little piece of it. (898)



Another way of effecting social change is through helping people become more aware of the consequences of their behaviour on others. Henrietta says that she occasionally employs this strategy:

You might not want to do it every time. But, ultimately, yeah, you have to do it because that is your responsibility, to help people become more aware of the consequences of their behaviour. (763)

Likewise, Penny declares that it is her responsibility to discuss the social repercussions of clients' actions (380). For example, she says that she asks clients, who are parents:

Do they feel they've wounded their children? And in what ways, and what are they doing about it? And I tell them that, until it stops, the world isn't going to be a better place. (421)

It is Penny's experience that through therapy, clients have become less isolated, and are able to connect with others in a far more positive way. She has seen them expand their interests, becoming involved in community organisations such as Amnesty International (403, 407).

Lorraine suggests that therapists take a very broad view, to help people become more aware of the consequences of everybody's behaviour on each other. Her goal is to help people awaken to connections with the world around them. She says:

[Therapy is] about becoming more conscious. About becoming more conscious about seeing how everything connects. And that so much of what we do is, we don't see how things connect. So, we don't understand it if we put bleach down the drain, that that is still in our water, and it never goes anywhere, and that it doesn't leave the planet ... We don't understand connections because we are disconnected from ourselves and we are disconnected from each other and then we are disconnected from the outside. (849)

She despairs about people unthinkingly destroying the planet, and not realizing how everything is interconnected (876).

I'm not helping people to be status quo. Because I'm helping people to awaken, and I think that adding to that consciousness, the more awake people that there are, the more likely that we are going to change things. (Lorraine, 873)

Phillip also uses the metaphor of 'awakening.' He says that psychoanalysis wakes people up to what is going on around them, putting them in the position to complain when they see something inappropriate happening in their environment (541).

Others are more indirect in trying to effect change. For example, Frank says:

In the back of my mind sometimes, I'm hoping that I'm developing a sense of anarchy in my clients, which is a sense that social, the social structure is something to be questioned. And social expectations are something to be questioned. Now, I'm not sure if I ever explicitly go through theories of social development with them, to show them how it all works or something. (465)

One way to advocate for social change, while at the same time benefiting the clients themselves, is through the use of a social analysis. For example, Catherine says that talking about social causes is the only way she knows how to help her poverty stricken clients. She says,

It never even crossed my mind, that I would do anything else with, or that anything else would be beneficial to those people. (788)

The use of a social analysis is not only helpful for people living in poverty. It could also help people who are working in jobs that pay a lot, but where the stress is just so enormous that they medicate themselves (Roseanne, 898). Catherine also discusses how the male middle class business-person is affected by oppression in society (e.g., of capitalism, of being a partner, of being a son). She says:

We live in a socially constructed world ... Nobody is self determining. We have so many forces being imposed on us, all the time. How could you not look at them, and say that, "No, we're all individuals." It's ludicrous. (791)

Cleo believes that teaching clients the world is socially constructed can be an empowering experience. He gives the example of a client, who had been beaten for something which society has constructed as being negative (i.e., being gay), learning not to blame himself (961). Myra gives the example of telling parents who have 'delinquent' children, how teenage vandalism and drinking is part of the process of breaking away from the family, as we have no

real rites of passage in this culture (659). Finally, Lorraine quite vividly describes why and how she incorporates a social analysis into her therapy:

The fact that you feel like a piece of shit isn't your own doing. Our whole culture and our whole capitalist structure is telling you that if you only had this, you'd be happy, if only you had that, you'd be happy, if only you had this, you'd be happy. And so, whenever I'm working with somebody in terms of how they make themselves miserable, [I tell them] it's not their own thing. Just watch T.V. and you'll feel miserable. Just go out into, especially with the women clients I work with, this is a male society. You never feel like you belong. (840)

Catherine says that clients do as they choose with the offered social analysis. She brushes aside the criticism that clients do not want a social analysis, by discussing the politics inherent in such a perspective:

Peter: I ask the other therapists, "Do you ever talk to your clients about the role of society and the role of the media and how that might play a role in how they're feeling and what they're feeling?" And ... some of the therapists say, "Maybe we talk about that a little bit, but they don't resonate as well to that as when we talk about their mother, their father."

Catherine: Whose judging? The therapist is supposed to ask themselves what are they comfortable with as well, right?... That is the traditional approach to silence, isn't it? That, you know, "Well I'm there to help somebody and this isn't really what they need, and this is what I perceive." I mean, you have to again understand that your experience is colouring everything, that you're perceiving as a therapist. So, possibly, whose discomfort is it? And who's description is it? Is it your discomfort that is coming out and therefore allowing the client to say that that is irrelevant?" (788, 789)

### C) Common Ground Regarding Therapy and Society

There is a certain amount of common ground among the participants (that is, between both 'the more prevalent position' and 'the less prevalent position') concerning therapy's relationship to society. Almost all of them define quite narrowly the benefits which therapy might bestow on society. In addition, they are all clear that the therapist should never lose sight of their primary responsibility, that is, to the client in the room. With respect to this last point, a number of them criticise certain therapeutic practices, that have the dual effect of harming clients, while upholding certain status quo societal arrangements.

I will now discuss these sub sub–themes: 1) Societal effects narrowly defined, 2) Client comes first, and 3) Status quo practices that harm clients.

### 1) Societal Effects Narrowly Defined

In discussing how much society can improve through therapy (either unintentionally, because of the natural domino effect, or due to the therapist acting as a social change agent), almost all the participants say that a realistic estimate of such benefits would be minimal, not exceeding the micro level. For example, Myra says that her work might lead to change, but not big social change (672). Similarly, Roseanne says that her work has affected minimal social change (916).

Most of the participants expect, at most, micro level change, and gear their therapeutic practices in that direction. For example, in going beyond the immediate concerns of the client, Martin says that he sometimes take into account the lives of other people in the client's life, but not society at large. "So we might attempt to understand some of the motivation of a family member, of a parent, a life mate, whatever" (581). Frank says that he consciously angles his therapy at the micro level:

Part of my therapy is always angled at changing the society that the child is in, but at a more micro level. Like, there's the child, there's the family, there's the school, then there is the more general level. Often part of my intervention looks at the family, almost always. And often the school as well, so there is kind of an outside focus, but it's still on a micro level, usually, so. (449)

Josh also says that, at most, he discusses the micro social context with clients. He often contextualizes clients' reactions with respect to their family or work setting, so that they could move beyond their sense of personal inadequacy. Ideally, this helps them overcome the idea that there is something inherently wrong with them, and, in the process, effects change in their immediate environment (687). He explains that he does not discuss the macro social context because, even though it could have been the original cause of clients' distress, their problems have moved beyond that:

What they may have is depression that, at this point, is almost autonomous from the root causes. It's now a pattern, a way of coping that they have learned, or a lack of other ways of coping. So, whether you call their problem now a social problem or not is insignificant. I mean, at this point, it may not be a social problem. (709)

Even though Josh prefers a larger domino effect, he says that it is only feasible to empower people to make micro social level change (e.g., family or work). He says that it is virtually impossible to affect the macro level (e.g., the economic system, culture of poverty stuff) since decisions are made internationally, outside of the country (684).

## 2) Client Comes First

In the previous section concerning the unintended domino effects which therapy can have, it was made clear by some participants that such positive social effects should not be a goal for the therapist (e.g., see Josh, 687). For those participants who believe that it is legitimate to strive for social change, they are also unanimous that the client still comes first. For example, Cleo says that his primary responsibility is to the client, and if it dovetails with his or her interest, he might also aim for social change (966). Michael says that he helps clients become less exploitive of others, primarily for their own good (309). Randy says that she advocates for her clients, to help them influence systems, primarily so that the client will benefit, but also because she wants the world to change (113). And finally, Catherine who desires social change, says that she ultimately does what the client wants "because it is oppressive to go against their wishes" (802).

Besides all of the reasons already mentioned throughout this chapter for the need to respect clients' wishes, Lorraine provides an additional rationale for focusing on the individual client. Her argument is that societal change is meaningless if people also do not change. She says:

I really believe that even if we change all the structures, all the people within the structures would be treating each other like shit, and we would be right back where we were. You can't transcend by changing the external structures, which is why people feel abused and burnt out, even in collectives. You have to

understand and change your internal make-up. [And] you could do them both at the same time. You don't have to naval gaze for ever, but can act at the same time. (848)

### 3) Status Quo Practices That Harm Clients

Almost all of the participants assert that they know of other therapists who engage in therapeutic activities that harm clients. Such activities mimic social conventions of which the participants disapprove, and can lead to the perpetuation of these conventions.

For example, a number of participants discuss the negative consequences of therapists who act authoritatively. They suggest that being authoritative in therapy can have the effect of perpetuating authoritative practices and behaviours in society. To illustrate, Lorraine says that she disapproves of therapists who believe that they are "the expert, and they've got it, and they're better [than their clients]" (860). Souhail and Martin both express concern that such therapists, who act like authorities and experts, telling people what they should and should not do, hurt their clients (Martin, 596; Souhail, 816). Martin goes on to say:

I think that they repeat what is done to a child. Who will give you some coping skills, who will teach you which feelings to feel, and not have an appreciation of the totality of the other human being. (596)

Marlene directly relates these practices to the societal level. She says that

There is this authoritarian structure in society that is screwing people up, and it's by being authoritative in therapy itself, you're just perpetuating what happens on a larger level. (93)

Another often mentioned example concerns the notion that many psychotherapists work to maintain their own institutional positions, regardless of their clients' needs. Alan, having experienced this directly, says that a number of his former fellow employees were not concerned with their clients but with "their jobs. Looking good. Stuff like that. Not willing to take a chance for the patient, because of hospital politics, for instance" (496). Myra laments the fact that institutional considerations have harmed her clients, who are now without certain inpatient services. In particular, she discusses why insurance companies no longer pay for

substance abuse, inpatient treatment centres, due to the unethical practices of some fellow psychologists:

What started off as the wish to help people very quickly got prostituted into money making, which meant, keep the beds full, no matter what happens, because that is how we make our money. And because of that, very inappropriate people were put into the wrong type of treatment, and didn't belong there... then the success rate was very low, and because of that, now there is no more funding. (651)

More generally, Souhail describes how therapists, especially those in private practice, can easily succumb to the desire to maintain their own status, while ignoring their clients' needs.

However, he sees a humanistic perspective as coming to the rescue:

Those therapists who are in private practice seem to be more preoccupied with the financial matters. A capitalistic society changes therapy into business. Therapists can easily fall into the trap of having a practice to suit their financial needs rather than patients' emotional needs. But if a therapist has a humanistic attitude then his financial needs become secondary. (812)

### III) Therapy in Professional and Cultural Contexts

The third core theme is that many of the views expressed by the participants are contingent on the professional and cultural contexts in which therapy takes place. That is, how one feels about the issues, of how power and values get played out in therapy, and the relationship between therapy and society, is related to a number of professional or cultural considerations. Among these considerations are: 1) facets of treatment, 2) values in the work setting and 3) therapist characteristics. Each of these sub-themes are now discussed.

#### A) Facets of Treatment

The views which the participants express concerning the above mentioned issues are contingent on at least three different facets of treatment. These facets of treatment are: 1) modality of treatment, 2) length of treatment, and 3) client characteristics. Each of these will now be discussed in turn.

### 1) Modality of Treatment

Almost all of the participants started out in their careers doing only individual therapy. A few of them, whose practices have evolved into a mixed model, that is, into doing both individual and couples or family work, say that their views on some of these issues have been partially shaped by this change. For example, Souhail discusses how this particular change in practice has effected the way in which he understands clients' problems. He says that he started conceptualizing the problems as being more family based than internally based, after he started seeing the family members of his clients. For Souhail, this change in practice happened for purely practical reasons, because the waiting lists were too long for the family members to be seen elsewhere (823).

Martin says that when doing therapy with more than one person, he can talk with more certainty about how others are feeling. In individual therapy, such comments are more speculative (583). Henrietta also discusses this phenomenon. She describes how she has gained greater awareness of the social impact of her clients' actions, as she has gained more first hand experience with the client's environment:

As I've been doing more marital therapy, and seeing couples, and just, the sadness of that. The cruelty that people show towards one another, who are in relationship to one another could be quite astounding. And that has really kind of struck me. And it's very different from doing individual work. Because doing individual work, you hear about the things that people do to one another, but you don't have to watch them, you don't see them. And, experiencing what other people can do to one another is quite different from only hearing about it .... If we see clients individually, we don't see the ramifications that they have on their family and their society. That we are not really seeing the whole picture. (745)

Finally, Penny provides a specific example of how, having a greater awareness of the social impact of clients' actions, effects the therapeutic process. In particular, she discusses two clients, both of whom had extra-marital desires. She describes feeling disapproval for one of them, having met her family, and feeling less disapproving of the other, having not met the family in question. She says:



With the one, on occasion, she brought her children in. So they are definitely visible ... Having met the husband ... the children, having had that type of experience, it does put a slant on the whole situation in a different light. It does. It does ... And that is one of the issues, I mean individual therapy, couple therapy, family therapy, which is the best therapy? Is it best to take the whole family system into account and realise that things are taking place in a context and that when each person makes a move, it affects the system? So, in that sense, I guess my perception was more systemic, more as a family type of situation. As opposed to this other situation where this woman is telling me that yes, she is involved emotionally with this man who is married and so on, but I haven't seen him. I haven't seen the children. I don't know anything there. So I can treat her as an individual. (60)

## 2) Length of Treatment

A few participants also discuss some differences that are associated with doing shorter term work as opposed to doing longer term work. Michael says that he focuses on making immediate changes with some shorter term clients, because they cannot afford longer term therapy. He says that they "don't have the luxury of indulging those long term perspectives or deeper issues [that might include employing a social analysis]. And I'm respectful of that" (311). In also wanting to respect his clients, Ross declares that the only responsible thing to do in crisis work is to help people with their immediate problems. For example, he says that he would not talk about theories concerning societal power relationships, and how the larger social structures are in part responsible for the person's distress, with a client who is scared of going home that night, for fear of being raped (618).

In longer term therapy, it might make sense to employ a social analysis, and aim for social change. It is harder to justify these goals when one is working with clients who have quite circumscribed problems. For example, Josh is of the opinion that social issues are irrelevant for people who go to therapy for very particular problems, such as for spider phobias. In such cases, he says that systematic desensitization is a more appropriate treatment than would be an in-depth therapeutic approach (704).

### 3) Client Characteristics

As mentioned in Chapter II, the demographic characteristics of the participants' clients are quite varied. To attest to the broad range of clientele, participants report working with: geriatric clients, convicted criminals, women in the correctional system, killers, rapists, men accused of battering their partners, thieves and petty thieves, clients who were sexually abused or assaulted, university students, adolescents involved with youth protection services, blacks, lower middle class clients, people who are indigent or on welfare, people living in inner cities, people in a sex therapy clinic, people in an addiction centre, people in crisis (Bob, 242; Bruce, 331, 363; Catherine, 774; Francine, 137; Karrina, 28,40; Luke, 185; Martin, 586; Myra, 663; Penny, 393; Phillip, 551, Roseanne, 907; Ross, 602; Tony, 13).<sup>45</sup>

Though participants see a variety of clients, most of them do not perceive a relationship between client characteristics and their choice not to utilize a social analysis in therapy. In response to my question, Bob says that his therapeutic approach is not dependent on whether the client is gay, Chinese or on welfare, since the same core issues are always involved (246,268). Marlene also believes that clients' issues are not related to their self identified group. She states explicitly that all clients regardless of economic status need only to harness their inner resources in order to overcome their psychological problems. In any event, she does not discuss with clients what she thinks might be causing their behaviour because she believes that it is not useful to dwell on the past (73,77,81). As already mentioned, another participant regards all of her clients as having the resources to master their problems and are therefore responsible for overcoming them, irrespective of their social station in life (Henrietta, 752).

A minority of participants discuss how their views are related to their clients' background, dynamics and value systems. For example, Mark says that different cultures have different issues which require that he works differently with them (999). Penny discusses

paying particular attention to cultural issues in working with Italian women who are breaking tradition (400). With clients who are vulnerable and for whom power is a big issue, Catherine says that she would try to maintain more of a value neutral stance (771). On one particular occasion, Catherine says that she did not share her opinion with a client "who was elementary in her development," believing that the client would introject it (772). Catherine goes on to discuss how difficult it was to maintain this stance since she finds employing a social analysis the only form of psychotherapy useful for poverty stricken clients (788).

A couple of the participants discuss how these issues play themselves out when working with people who hold values similar to their own values. For example, Francine, being a fundamental Christian, says that she is more comfortable sharing her values with fellow fundamental Christians (142). She describes a particular situation, where she shared her belief system with a client who was involved with a married man:

She sort of was asking me to help her, not pull it off, but to help her feel o.k. about this. And I couldn't do that. And I told her that I believe that what you are doing is wrong.... Coming from the same belief system, on one level she knew that to do what she was doing wasn't really what she believed either. (158)

### B) Values In The Work Setting

The values that inhere in the political milieu can play a role in determining how much social importance a therapist attaches to his or her own work. For example, being a psychologist in a third world country can be understood as being illegitimate, without much use to the population, and without much political significance (Karina, 43). In North America, participants say that they often find their work meaningful. By acting on their values and beliefs, they discuss their opportunity to effect small scale social change. However, they also say that they are sometimes constrained to express and act on their beliefs, depending on the work setting within which they find themselves.

For example, Francine says that she employs standard diagnostic categories in the hospital, that is against her better judgement, because "that is the way we talk down there [isz. referring to the wards with the other professionals]" (152). More generally, she says that, in working in, and by implication representing an institution, she cannot act on certain values:

There is less liberty to be who I am, and to say what I think ... In therapy, I am far less apt to communicate about certain kinds of values within this setting, simply because I feel in some ways I'm representing not just myself here. People come here with a certain expectation, that in some ways you're representing this institution, and you are, I am. (159)

As a result, she says that she is starting to do more private practice. In a private setting, she expects to be able to do more of what she would prefer to do,

by selecting a group of people where I feel I can be more open with what I believe and who would want that, and where it might make a difference for them, because they are operating within the same religion. I can't do that here. (160)

Phillip, who also works in a public institution, also discusses the costs associated with having to conform to institutional standards. For example, he declares a preference to interpret clients' murder threats as them wanting to murder an aspect of themselves, but instead he takes the threats seriously. He explains: "Since I'm working at the clinic, I have to conform to the clinic's standards" (529). More generally, Phillip talks about having to practise according to societal values because of the potential threat of a lawsuit (532). He says: "I'm afraid of litigation, losing my license. And if I got so anxious that I was worried that society would take away my license, I might alter what I really believe" (532). Being an American, Phillip laments that the need to fashion therapeutic practices to meet the requirements of societal standards will only increase with the threatened expansion of American national mental health care. He says:

If therapists are being paid by the national government, then they are going to be obligated to say, that once you're getting payment like that, going through a third party source, you are kind of saying that you are working for the government. And the government is going to have its own societal standards, depending on who's in office. And they are going to have to conform to those

societal standards. [For example] if the patient knows that you are going to have to call some mental health agent, tell them what the symptoms are, how therapy is progressing, to get more money, that is going to definitely affect the confidentiality of therapy. It is going to affect what the patient brings to mind .... Or the insurance company might think that medication is the treatment of choice, and won't pay for psychotherapy. (544)

### C) Therapist Characteristics

A broad range of psychotherapists were sampled in terms of characteristics such as gender, political perspective, sexual orientation, therapeutic approaches, work settings, length of experience, types of clients, etc. It is difficult for me to determine the role these characteristics play in the formation of the expressed opinions. For example, the two main perspectives concerning therapy in the societal context (ie. the more and less prevalent positions) are not easily divided in terms of these characteristics. In addition, participant views are not always internally consistent, the themes are meant as caricatures that do not necessarily represent the views of any particular participant or sub-group of participants, and there are few if any participants whose demographic profiles perfectly match with each other.<sup>46</sup>

However, a number of participants discuss their opinions concerning the impact of certain therapist characteristics, such as training and experience, on one's perspective concerning therapy's impact on society. For example, Roseanne asserts that most of her fellow mental health professional employees believe that psychologists should stick to working with a client's internal dynamics because only social workers are equipped to deal with social issues (911). This view, that psychologists are more individualistically oriented, and that social workers are more socially oriented, is shared by other participants as well. For example, Catherine says that

social work, in a sense, comes from a different base. Instead of, I think of psychology as traditionally being an individual model, I think of social work, more being, taking into consideration some of the social dynamics. (769)

Coming from a social basis, Catherine says that it is not only legitimate, but it is a requirement that social workers get involved with a client's social world:

Finding someone housing is a complete therapeutic issue... to help them work with the system, or get their welfare cheques or whatever, I think that is completely integral to therapy. (776)

Myra puts a negative spin on her observation that social workers, unlike psychologists, feel overly responsible to make social changes, which they believe would help their clients (642). She assumes that this difference stems from the different training programs in the two professions:

When you look at the education, you come through social work, you're looking at family systems and social systems as a unit, and you come into psychology and you're interested in individual differences, and intra-individual, such as motivation and stuff. (642)

However, not all of the participants accept this analysis. For example, Frank is unwilling to say that his views about the individual and society are attributable only to his training. He says that the values which he held prior to entering the profession also play a role:

I'm having difficulty distinguishing between the two because my values have been shaped by what I understand about psychotherapy, and the way I do psychotherapy have been shaped by the values I have, so that somehow they have started to mix together. So that, sure, when I'm seeing a family, and the family is scape goating the kid, I don't like that, you know. I don't think that is a good way to be with a kid. Now, why don't I like that? Well, probably because I just don't like that, but also because I've got ten books that tell me why I don't like that too. (438)

Finally, Lorraine says that one's views are contingent on one's prior political beliefs. She maintains that if one already believes that there is nothing wrong with society, then there is no need to question the status quo. A therapist would aspire to be a social change agent only if he or she believed that society was in need of change (874).

## CHAPTER IV

### DISCUSSION

In this chapter, the data that were presented in the previous chapter will be examined in light of Lather's (1991) theoretical approach. In essence, her approach acts as a theoretical template, and is overlaid on the actual procurement, development and presentation of data, as well as on the data's relationship to existing theory. Specifically, the research process and its results are analyzed with respect to four components of Lather's approach, each of which will be treated separately. They include: 1) An analysis of the methodological safeguards that were incorporated into the study's design; 2) An examination of the contextual nature of the presented themes, in light of general cultural factors, and specific research considerations. The analyses with respect to these first two components are intended to help clarify the relationship between the constructed themes and the participants' pronouncements;<sup>47</sup> 3) An examination of the project's ability to provide participants an opportunity to think about these issues, and to develop emancipatory knowledge; and 4) An examination of the relationship between the themes and the critique of mainstream clinical psychology presented in Chapter I. The result of this last analysis is a theoretical approach that reflects both the experiences of real live psychotherapists (Chapter III), as well as the critique (Chapter I). In the fifth section, implications of this project are offered along with suggestions for future research.

#### Methodological Safeguards

Lather (1991) advises that research that aims at developing critical theory embody the concerns of real people. To counter the possibility of theoretical over-determinism, participants must be afforded the opportunity to express opinions and beliefs that potentially conflict with, though are still relevant to critical inquiry. She demands that flexible research practices, that

are responsive to the ever changing needs of the inquiry and to the research participants themselves, be utilised.

I will first list some methodological procedures that were used in order to satisfy these requirements. Then, I will offer more general grounds for accepting that the presentation of data in the present thematic form adequately represents the participants' pronouncements.

First, this project relied on an emergent rather than on a static design. This means that the methodological principles were subordinate to the context and to the particular subject matter. Because the ongoing interaction between investigator and context was not pre-ordained, the design was played by ear. As Lincoln and Guba (1985) characterise this type of design, "it unfolded, cascaded, rolled, and emerged" (pp. 209).

For example, the actual selection of participants was not predetermined. The number and demographics of the participants that were sampled depended on the results of the ongoing analysis (also see Burgess, 1984; Guba & Lincoln, 1989). In addition, a flexible interview format allowed the project to be responsive to participant's inputs. For example, the interview guide changed a number of times, reflecting in part some of the concerns and issues raised by previous participants. Also, as the interviews progressed, they became less structured and more open ended. This flexibility allowed for a reciprocal give and take between researcher and research participants, thus broadening the scope and meaningfulness of the inquiry. It lessened the interviewer's power to name the participants' world. The participants were treated with dignity, giving them a considerable role in the process. For example, the participants framed the issues as they saw fit. In addition, incorporating the option of a second 'member check' contact further empowered them. That is, the transcribed interviews were returned to the participants, and they were given the option (either in writing or in person) of deleting, correcting or amending the transcript, prior to its being analyzed.<sup>44</sup>



Second, analyzing the interview transcripts through the dual lenses of Grounded theory and Critical social science yielded themes that reflect the participants' understandings of the issues, and also acknowledge the role which power and domination plays in the participants' expression and the researcher's interpretation of offered constructions. Evidence for this lies both in the content of the constructed themes (e.g., themes dealing with therapist and client power), as well as in the contextual examination of the research process itself (see next section).

More generally, Rennie et al. (1988) suggest specific criteria for establishing whether the researcher's thematic presentation reasonably represent the realities of the participants. I will now present those criteria and describe how they were met.

Rennie et al. (1988) maintain that the analysis be grounded in appropriate procedures, and that it present a comprehensive account that does not omit large or important portions of the data. These requirements were met by rigorously following Rennie et. al.'s (1988) suggested procedures for carrying out Grounded theory. For example, all of the interview material, that was transcribed verbatim, was chunked into meaning units. These meaning units were condensed into summary statements and collapsed into themes (for an extended discussion, see the analysis section in Chapter II).<sup>49</sup>

In addition, the comparable criteria of dependability and confirmability are met by utilizing procedures that made the interview process responsive to participants' inputs (see previous discussion), as well as through the keeping of an audit trail. That is, all raw data were coded so that they are traceable to their original sources, and records of the rationale for the changes in research themes, sub-themes, etc., are trackable, that is, they are open to public inspection.

Rennie et al. (1988) argue that the analysis be believable in that it seems to the reader to be a plausible explanation. With respect to this criteria, it is presumed that there will be

varying degrees of acceptance of my ability to make sense of the interview material. That is, it is assumed that readers' agreement with the thematic schema will depend on their own perspectives. By not assuming the identitarian possibility of pure representation, it is acknowledged that explicatory actions that are open to differing interpretations, were necessary. The legitimacy of these explanatory actions are intended to be judged on the basis of how probable they are and not on the basis of some unattainable goal of certainty. It is understood though, that due to practical considerations, this judgment must ultimately be an inter-subjective one.

### Contextual Nature of the Themes

Central to Lather's (1991) approach is the belief that the production of knowledge does not occur in a cultural, professional, or power vacuum. Given its contextual nature, she stresses the need to identify the particular circumstances surrounding the research process. Following her advice, I examined the general context surrounding the interviews. I also looked at some of my own, as well as some of the research participants' preconceptions. I explored how we positioned ourselves with respect to the material that was presented, and examined our interactions with each other, paying particular attention to the role that power dynamics played in the production and presentation of material. I will now discuss these contextual factors.

With respect to the general context, core theme three explicitly addresses the participants' conceptualisations of how professional and cultural issues shaped their views on therapy and society. On a more implicit level, it is also conceivable that the societal context played a role in the participants' choice of topics, and in the manner in which they were discussed. For example, a number of participants mentioned some of the hot social issues of the day, e.g., gay and lesbian issues, and women's rights, issues that might not have been

discussed 30 years ago. In addition, these issues were not framed in terms of 'collective rights' or 'collective responsibility.' Instead, they were generally discussed by the participants in terms of the need to respect the rights of the individual. Most participants understood individuals as being capable of utilising their own inner resources, that they should take responsibility for their own actions. To repeat Ross's belief, one important reason for participants assuming this understanding was because of their belief that "that is the way our culture works" (610).

The societal context dictated not only the significance attached to clients' rights, but arguably also impacted on the decision by most of the participants to focus on clients' immediate concerns. That is, the interviews were conducted in the midst of an economic downturn, and as Michael says, during recessionary times, people are most worried about losing their jobs (287). In such a climate, some participants might have felt obliged to express that their primary duty is to help clients get through hard economic times. During the 1960s, these same humanist participants might have described having an expanded therapeutic agenda, e.g., emphasising 'growth' or spiritual concerns. In today's political climate, these participants did not mention such solutions, since it is now arguably more fashionable to help people 'pull up their own bootstraps' instead.

Society's present infatuation with political correctness also might have impacted on the interview process. Most participants expressed what could be characterised as 'politically correct' views, e.g., that everyone should be treated equally, that one should not impose his or her views on others, etc.. By today's standards, the interviews did not contain very controversial remarks. An exception was the participant who admitted to feeling uneasy about helping homosexual clients become more comfortable with their sexuality. Concerning this expressed unease, he remarked: "It's just politically incorrect to be saying what I'm saying" (Robert, 265). One can only speculate on what the interviews would have consisted if different

views were considered politically correct (That the way in which therapists conceptualised power also echoed popular conceptions will be discussed in a later section).

Examining the narrower context, one might consider the possibility of implicit agendas underlying some of the participants' verbalizations. For example, some participants appeared to approach the interview as an opportunity to express some of their philosophical positions on life. One participant in particular came across as selling her brand of therapy, and appeared to be having a difficult time listening and responding to my questions. A second participant said that,

I believe that I was speaking, on some level, to the scientific community. And the message was, I'm feeling like I want to move into some expletives here, the message was, you're all wrong. You don't get it. And it's not just that you don't get it. It's that you don't want to get it. (Robert, 283)

A third participant, whom I felt misunderstood some of the questions, nevertheless explicitly said that she had been thinking about similar issues lately. At that point, it occurred to me that the interviews were similar to a projective test. That is, participants appeared to be focusing most on the issues that are most important to them.

Another hypothesis is that some participants presumed I was some sort of radical, and had a socialist agenda. I could almost imagine some of them wondering this, and asking themselves, why else would Peter be interested in these topics? Fearing that authoritarian tendencies inhere in a socialist inspired analysis, they might therefore have felt obliged to emphasise the agency of their clients. If this were true, this would be analogous to Lather's (1991) positioning, which is also against the dangers of Marxist Hegemony. This interpretation is consistent with a second observation. It seemed that when I was expressing support for the supposed norm, that the client should get what they want, some participants then emphasised how their own agendas play a role in the therapy.

Another set of theories involve the observation that many of the participants spoke in generalities even though I had asked for specific examples. Many of the participants also

appeared to be somewhat guarded in what they said. In fact, a couple of participants expressed feeling somewhat anxious and exposed at times during the interviews (Frank, 446, Lorraine, 889). A number of factors may explain these observed actions and feelings. For instance, they might have been due to the participants' limited prior experience discussing these issues, to the demand inherent in formulating novel ideas, to an expressed fear of exposing their clients, to reticence of criticising their professional colleagues, or to my relative lack of success at creating a safe enough environment to accommodate these possible influences. Alternatively, it is possible that speaking in general, guarded terms reflects a 'normal' state of affairs. That is, it is arguable that most therapists are trained to express themselves in broad, noncommittal terms. Therapists are taught how to facilitate their clients' verbalizations of intimate beliefs and feelings, and how to be extremely careful concerning the expression of their own beliefs and feelings. As one participant said, in response to a question concerning the approaches she uses in therapy, "You know how much therapists hate being pinned down like that" (Francine, 141).

In a more theoretical vein, how the material was discussed might have reflected the linguistic resources that were available to both myself and to the participants (see Hollway, 1989). At times, it seemed that certain concepts about which I asked were foreign to the participants' linguistic awareness. For example, without a background in the critical literature, it appeared to be a difficult task for a number of the participants to appreciate the significance of the empowerment process having a social component. Another example concerns the different discourses available to a liberal-humanistic versus a socialistic perspective. That is, a liberal-humanistic inspired discourse acknowledges the role of values, while condemning talk of socially engineered change. Socialistic inspired discourse promotes the advantages of top down change.

One can also argue that having different linguistic resources, or frames of references, broadened the scope of the interviews. For example, when I first started asking participants for their views on how therapy perpetuates the status quo, I had a clear expectation that they would discuss whether or how therapy's individualistic focus contributes to the individualist ethic in society. However, a number of participants instead discussed a very different issue, that is, the danger of authoritarian therapists perpetuating authoritarian tendencies in society. Another example involves the question of whether participants treat clients from different backgrounds differently. I initially assumed that a negative response would indicate that they were making the simplistic assumption that the world is monolithic. Instead, a number of participants discussed how having different approaches for clients of different backgrounds meant that the therapist was being controlling. Having the same question elicit unexpected responses points to an important feature of qualitative work. That is, it allowed participants the freedom to interpret the questions, as they saw fit.

I also considered how my perspective affected the interviews, and how my approach changed over time. For example, I came to the realisation that, in examining the relationship between psychotherapy and society, I did not distinguish between the specific schools of psychotherapy (e.g., cognitive, behavioural, psychodynamic, etc.). Instead, I found myself searching for commonalities that cut across the issue of technique. It is acknowledged that a good case could be made for the notion that different values underlie the different psychotherapy approaches (see Prilleltensky, 1994).

About half way through the interview process, I made a conscious effort to modify the tone of the interviews. While allowing the participants more leeway to discuss the issues as they saw fit, I also became more direct in the questions which I did ask. Instead of trying to infer the participants' opinions from general queries (e.g., asking about goals in therapy, or about easiest or most difficult clients), I more directly asked whether they believed themselves

to be powerful, and how their values get played out in therapy. Most of the participants appeared to be comfortable with this more direct approach. They probably knew that I was trying to get at this material anyway and not asking about it directly might have been getting in the way of having an open and frank exchange of ideas. In fact, I believe that the richest material emanated from these more direct queries. However, it is also possible that a few participants were uncomfortable with the direct questioning, and this therefore had the effect of artificially narrowing the scope of those particular interviews.

As the interviews progressed I became increasingly conscious of the power dynamics in the room. These power dynamics appeared to oppose the norm that operates in most research. It is usually the researcher who is perceived to be more powerful vis a vis the participants (Lather, 1991). In the present research context, my position as a graduate student practitioner/researcher might have cast me in a less powerful position vis a vis many of the professional mental health care workers/participants. For example, it felt like certain senior professional/participants were trying to educate or socialize what they perceived to be an idealistic, naive junior professional student/researcher. That is, it felt like they were implicitly warning me against naively believing my theoretical critique of therapy. It felt like these particular participants were trying to teach me the realities of working everyday, with clients' real concerns. Alternatively, the participants might have cast me in a powerful position, given that I was the researcher who was asking almost all of the questions. Assuming this alternative, the implicit warnings and teachings might be interpreted as reactions against what they perceived as Peter trying to impose a socialist agenda on them, and/or on the data. However, to assume this alternative means that the participants also had sufficient power vis a vis the researcher to express these sentiments.

In addition, reading over some of the transcripts, I noticed a notable lack of critical questioning during the interview process on my part. It is possible that this was due to my

reluctance to criticise certain senior mental health professionals. At times during the interviews I became acutely aware of my wish that some of them accept me, that I not get on their 'bad side.' I wondered whether I was feeling intimidated to agree with their views because they had more experience, and, more importantly, because I might be asking some of them for references, or maybe even for a job in the future.

It is possible that these power dynamics also had a lingering effect during the Grounded theory analysis stage. For example, these power dynamics might have affected the scope of certain meaning units. That is, considering the immense amount of raw data, judgement calls were required to determine whether each expressed thought or idea should be considered separate meaning units, or whether they should be treated more generally in terms of shared topics. In sometimes consciously choosing the latter option for pragmatic purposes (the analysis still generated over 1000 meaning units, resulting in a relatively lengthy write up), it is possible that I was also unconsciously overlooking some specific phrases that poorly reflected on some participants, again, for fear of criticising them.

It is also possible that some of the data generated by the interviews were, in fact, excessive. During the interviews, I occasionally encouraged participants to discuss some of their pet issues, which I knew were not particularly relevant to the study. This was done in order to develop rapport, so that they would feel more comfortable discussing the issues in which I was more interested. In fact, I felt that I had good rapport with almost all of the participants. Most of the interviews felt very comfortable to me, and many participants explicitly expressed enjoyment participating in the process (e.g., Alan, 495; Francine, 184; Lorraine, 889; Michael, 316; Myra, 643; Penny, 401; Phillip, 572; Randy, 136; Robert, 282).

Power dynamics might have also affected my choice of themes. For example, I realized that I did not concentrate the thematic presentation on participants' misunderstandings of how I originally defined power, or on how some of them did not



seriously consider the social implications of their work. Instead, I looked more favourably on the participants' perceptions. It is difficult to determine whether this change was completely voluntary, whether on some level I still felt intimidated by the participants, whether I feared the charge of being biased, whether I wanted to please my committee members who are also fellow psychologists, or whether after having spent literally thousands of hours poring over the transcripts, I had an experience similar to the Stockholm syndrome. This is where hostages, after spending 'quality time' with their capturers', start to adopt their capturers' point of view.

Given all of these contextual factors, it is expected that a different thematic schema would result from another researcher's efforts, who might conduct a similar study in a different time and place. However, if one makes the assumption that beliefs are relatively stable entities, it is probably safe to assume that the presented themes reasonably represent this group of participants' expressed beliefs. It is doubtful that in a different set of circumstances the participants would have been much more forthcoming, given the generally good rapport developed during the interviews. Also, that the participants would probably agree with my representations is all the more likely given its relatively sympathetic reading.

### Developing Emancipatory Knowledge

Raising potentially controversial topics in a relatively intense one-on-one interview setting challenged the participants to consider issues about which they might not otherwise think. It provided a channel for the participants to examine their values and raised their awareness of some of these issues. Evidence supporting the achievement of these goals comes from the testimony of some of the participants. For example, Francine says that the interview was thought provoking (184). Myra says that the interview was stimulating, that it made her think (643). Both Francine and Lorraine also say that the interviews gave them an opportunity to become more aware of some of their beliefs, and to better integrate them with

their therapeutic practice (681, 889). Phillip, in commenting on the interview process, describes the importance of putting unformed thoughts into words. He also says that he rarely has a forum in which to discuss these beliefs:

I rarely get to talk about these things. And you know more about what you do know when you are able to verbalise it, and put it together and understand it. So, it was good, it was fun. (572)

Frank also bemoans the fact that his colleagues are uninterested in talking about these issues (424). He goes on to say that "the more that I can figure this stuff out, or work on it, the more useful is what I can offer (to my clients)" (457).

Other participants also comment on the professions' general lack of interest in these issues. For example, Catherine says that the social work profession does not sufficiently evaluate the role of therapy in society (765). Cleo doubts that graduate programs in psychology would be willing to spend much time examining these subjects (971). Further evidence that these issues are rarely discussed is that none of the participants expressed knowledge of any of their colleagues' opinions on these topics.

Encouraging the participants to think about their power, and to re-examine their previous ways of looking at things made some of them more aware of contradictions in their thinking, that were previously distorted by everyday understandings (As previously stated, Lather calls this type of awareness 'emancipatory knowledge'). For example, Penny says: "I think this is significant, that in talking about this, I've become aware of some of what I do in therapy that I wasn't even all that conscious of" (417). Mark, having had the opportunity to reflect on these issues, says that he now realizes that he indeed imposes some values in therapy. He remarks: "You know, actually, when I think of it, um, it's interesting. I always say, 'I don't impose values.' But I do ... It's a learning experience" (1010).

At the end of the interviews a few participants express the wish that therapists in general should become more aware of these issues (e.g., Henrietta, 735; Catherine, 765).

Souhail says that he hopes my work inspires others (831). A few of them also say that they intend to re-engage in this sort of dialogue and further their own understanding. For example,

Mark says:

[As a result of this interview] I feel I have done some questioning for myself, which I feel is healthy and good. I think it's an opportunity, and it would probably be good if it happened even more often. To question the things I believe in, and how they influence the work I'm doing. (1008)

However, whether the interviews actually lead to the lasting development of emancipatory knowledge is unknown. I have no knowledge whether the participants were inspired to actively consider these issues outside of the interview. Time constraints forced me to cancel the proposed follow up interviews to investigate this. However, with respect to Lather's (1991) notion of transformation, the research process has definitely changed me. Though it has not changed my general beliefs concerning psychotherapy's impact on society per se, it has deepened my understanding of the conflicting issues, and more particularly, has helped me refocus on the importance of respecting clients' power (discussed in the next section). In addition, even if the participants do not reconsider these issues, maybe the work can serve a transformative role for others who read it.

#### Relationship Between the Themes and the Critique

I will now scrutinise the content of the participants' pronouncements, in light of the critique of mainstream practices in clinical psychology presented in Chapter 1. This give and take process, comparing and contrasting the critique with the data grounded in the experiences of real people, should provide a more informed understanding of the relationship between psychotherapy and society.<sup>50</sup>

Privileging the concepts of power and emancipation, I will first summarise 'the more prevalent position' and compare it to the critique of mainstream practices presented in Chapter 1. I will then summarise 'the less prevalent position' and compare it to this critique. Following

this, I will discuss how a dialectical approach might account for the discrepancies between the critique and the participants' views.

Most participants (that is, 'the more prevalent position') do not conceptualise their work as perpetuating the structural conditions that act as a barrier to the mental health of their clients as well as society at large. Though they recognise therapy's individualistic focus, they do not consider therapy as negatively contributing to the individualistic ethic in society. On the contrary, they believe that the effects of therapy naturally generalise, so that society indirectly benefits from their work. Therefore, they do not see the necessity for further questioning therapy's relationship to society, or for developing socially informed clinical practices. In addition, most of them acknowledge their own power and the role that their values play in therapy. However, they stress that they often try not to impose values on their clients, who they believe are powerful themselves. They speak of their wish not to aim for social change through therapy, saying they did not become therapists to change the world. They declare that this is not part of the therapeutic contract which is to give clients what they want.

The more prevalent position supports most of the basic assumptions of mainstream psychology outlined in Chapter I. Thus this position reinforces: 1) that it is unimportant to spend time questioning therapy's relationship to society; 2) that social change is not part of therapists' mandate; 3) that therapists can keep their values out of therapy, and; 4) that individual clients' concerns should be privileged. However, in adopting the almost unanimous twin beliefs that therapists are powerful and that the potential for therapists' values playing a role in therapy is great, it seems that the more prevalent position does not strictly conform to the mainstream assumptions against which the critique in Chapter I is situated, since the critique assumes that psychotherapists do not reflect on their power. To account for the discrepancy in these participants' seeming acknowledgement of their power, one could say that they adopt a different conception of power. That is, in terms of the critique's definition of

power, advocates of the more prevalent position could be seen as not recognizing the role that their power and values play in relation to maintaining societal power structures.

To remind the reader, the critique in Chapter I relies on a mix of Foucauldian and Gramscian conceptions of power, both of which share common ideas about power being related to a structured hierarchy in society. This sense of power gets dropped when these participants mention the term because their discussion of client and therapist power has a very different theoretical base which is derived from a liberal-humanistic perspective. From this perspective, all people are seen as having equal power, the assumption being that everyone has an equal chance to compete (Dworkin, 1990). It then becomes an issue of examining obvious manifestations of power in the therapy room. It becomes a matter of whether therapists explicitly determine clients' behaviour or whether clients control their own behaviour. This contrasts with the issues discussed in Chapter I pertaining to how power emanates from a structured hierarchy in society.

To expand on the differences between the critique's and these participants' understanding of power: From the critique's Foucauldian and Gramscian perspective, power is viewed as being productive and as being a fundamental component of all action. That psychotherapists are particularly powerful, and thereby have far reaching social effects, is also supported by their hegemonic position in society. The critique makes the assumption that a recognition of their power would necessarily lead therapists to try to harness such power in the service of positive social change, rather than lead them to undertake the impossible task of trying to eradicate its effects.

These participants on the other hand tend to construe power in relatively narrow terms, relying on more mainstream, liberal-humanistic conceptions. Though there is some recognition of the institutional basis of their power (similar to Gramsci's conception [see Sullivan, 1984]), they only consider its immediate manifestations, that is within the therapy room itself. They

understand their power as being mostly prohibitive, conceptualising it as a force for controlling others and as something that can and should be controlled. Unlike Foucault (1967, 1977), who sees the productive potential in all power, these participants see the conscious exercise of their own power necessarily having authoritative effects. Therefore, in recognising their power, participants attempt to restrict its impact on their clients and on their clients' immediate environment. In addition, they believe that their own power diminishes by assuming that clients control the therapeutic process, and by respecting clients' choices.<sup>51</sup> Since they feel capable of controlling the impact of their power, they do not regard their lack of concern for the social ramifications of therapeutic work as constituting a socially irresponsible act.

Besides its congruence with a liberal–humanistic perspective, the choice to conceptualise power in narrow terms might also be related to these participants' difficulty in being practically able to apply the more broad based alternative. That is, some participants suggest that they would expand their focus if not for certain pragmatic reasons. They maintain that the lack of time, of perceived resources, and of their clients' readiness for social analysis compel them to focus on their clients' immediate concerns.

A narrow conception of power has the added advantage of allowing these therapists to maintain their humanistic belief in people's goodness, thereby lessening their feelings of discouragement. It might be more difficult to preserve this belief if they were constantly confronted with examples of societal oppression. Narrowly defining their power also permits these participants to employ relatively restrictive criteria for defining success. For example, therapy might be considered successful if clients report improvement, regardless of the direction or amount of social change. That it is a relatively easy task to accomplish these limited goals allows therapists to maintain their power base in society. On a more theoretical note, the critique in Chapter I is concerned with the unobservable effects of power. For

therapists who are immersed in their clients' day to day machinations, it might be difficult to appreciate unobservable effects outside their normal range of experience.

These participants' views are also similar to Szasz's (see Sedgwick, 1982) libertarian politics and his belief in radical individualism. That is, insofar the therapeutic profession is considered an instrument of the state, these therapists (like Szasz) believe that their individual clients should be as free as possible from the constraints of their profession. Their views are also consistent with the humanistic notions that individuals determine their own futures and naturally benefit others, by tapping into their 'essential goodness,' and by harnessing their own power to creatively adjust to their immediate environments.

Extrapolating from the presented material, advocates of the more prevalent position understand emancipation as referring to self-knowledge or self-assertion. They appear to believe that the empowerment process is highly personal, and has nothing to do with structural inequalities (even if they do exist). This laissez-faire therapeutic approach focuses exclusively on the individual's strengths and weaknesses in facilitating the empowerment process. This contrasts with the critique presented in Chapter I which incorporates a social critique in the emancipatory project. The critique emphasises the existence of social and structural inequalities and stresses the need to create the conditions whereby people will have the capacity to be free to choose (also see Dworkin, 1984).

Given the above, critics who subscribe to Foucauldian/Gramscian conceptions of power and emancipation might label practitioners who advocate liberal-humanistic notions as 'oppressors,' whose therapeutic practices help maintain oppressive societal power structures. These liberal-humanist participants might be seen by critics as contributing to the oppression of an already oppressed group, that is, of people who are already in pain. Critics might argue that empowering clients by first telling them they are sick and in need of treatment, rather than discussing the role of social factors in the genesis of their discomforts, has the affect of further

reducing clients' power within society. Participants' defense of their practices through a discourse of rationalization, which implies that they are merely following clients' wishes, might also be construed as oppressive.

Critics might also accuse these liberal–humanist participants of adopting a poorly thought–out perspective. These participants might be criticized for denying the need to examine the relationship between therapy and society. They might be accused of producing accounts replete with contradictions concerning the relationship between their own power and their clients' power, and denounced for either side–stepping these contradictions or for offering overly sly strategies to down–play these contradictions. For example, one participant might be rebuked for rationalizing his choice to explicitly exercise his power by refusing to work with an abusive client in the name of liberal–humanist ideology, especially in light of his later comment that there is a real authoritarian aspect to teaching people one's ideological perspective about how society works (Josh, 699, 706). Similarly, the participant who says that she is not powerful because she cannot explicitly force her clients to do anything, in light of numerous theories concerning the powerful affects of subtle psychological processes on human functioning, might also be criticized for not fully thinking out her perspective (Lorraine, 846).

I believe such critical judgements to be simplistic. For example, it might be wrong to blame these participants for their lack of reflexivity or for their relatively incoherent perspective, since their liberal–humanistic ideology is so implicit in their training that their commitments to the individual blinds them to other social realities. More important, a number of important contributions are associated with the liberal–humanist emphasis on client interests (discussed below). Nevertheless, certain negative conclusions regarding the adoption of a liberal–humanist stance are warranted.

Adopting a liberal–humanist stance increases the likely occurrence of certain negative social consequences. For example, as indicated in Chapter I, the individualism contained in



the participants' doctrine of self-actualization mitigates against encouraging clients to use their power for social change (Buss, 1979). In addition, it may be misleading to consider the channelling of their clients 'essential goodness' as naturally resulting in social change, without any outside impetus. As Prilleltensky (1992) says, "The individual spiritual elation and happier general outlook on life that may be occasioned by humanistic therapy do not automatically translate into steps for a better society" (p. 320). On the contrary, he points out that it is dangerous to foster the belief that a better world inevitably results from humanistic therapy practices.

This is a dangerous perception, for the "belief in a transformation that is happening in fact keeps it from happening" (Marien, 1983, p. 7), simply by deflecting attention from structural, material, and economic concerns. (Prilleltensky, 1992, p. 317)

This sample of participants includes a second, less prevalent perspective concerning therapy's impact on society. I will first briefly summarise the less prevalent position and its relationship to both the more prevalent position and Chapter I. Then I will discuss the less prevalent position's conceptions of power and of emancipation.

The less prevalent position is similar to the more prevalent position with respect to its conceptualization of therapist-client power relations (core theme 1). However, those subscribing to this position are more sensitive to the critique of mainstream notions concerning therapy in the societal context (core theme 2). Likewise, their understanding of power and emancipation is somewhat more compatible with understandings advocated by the critique in Chapter I. Consequently, those subscribing to this position could be considered to be adopting the liberal-humanist ideology to a somewhat lesser degree than the majority of participants.

Those subscribing to the less prevalent position are critical of the social effects of therapy's almost exclusive focus on the individual. In order to combat these negative effects, those holding this position believe that therapists should be more pro-active agents of social change. For example, they sanction an analysis of how societal power arrangements effect

clients' functioning. These beliefs are similar to Chapter I's critique, and in contrast to the more prevalent position.

Advocates of the less prevalent position often define 'the social' quite narrowly, so that it encompasses only the micro level. They also see the therapist's primary responsibility as being to the client in the room. This parallels the more prevalent position, while differing from the critique's more macro level definition, and its recommendation that the therapist have a co-equal responsibility to both the individual client and to society at large.

With respect to their conceptualisation of power, advocates of the less prevalent position mirror supporters of the more prevalent position in not fully exploring the conflict between therapists' power and respect for clients' power, and in also offering a discourse of rationalization to account for the apparent contradictions. Nevertheless, this position is more compatible with the notion that therapists' power be used constructively for emancipatory ends. That is, in acknowledging the productive capacity of therapist power, supporters of this position advocate harnessing power in the service of positive social change. In addition, their definition of emancipation includes facilitating the process of individuals choosing their own course of action, based partly on their analysis of the social causes of their powerlessness (though the social is not always broadly understood).

Supporters of this position apply a specific feminist contribution to therapy. That is, they suggest that therapists present themselves as role models who believe that a complex life is possible (see Cammaert & Larsen, 1988). Maintaining this position is also congruent with a good deal of Prilleltensky and Walsh-Bower's (1992) moral ethical imperative. To repeat, this moral imperative obliges psychologists to contribute, pro-actively, to the advancement of the 'good' society. Maintaining this position complies both with this imperative and with the suggestions for implementation, by reflecting on the social consequences of therapeutic work, by respecting the capacity of clients to select their own goals and to defend

their own interests, and by pro-actively taking actions intended to foster the well-being of both clients and the community. One might take exception however to this position's particular focus on the individual's immediate environment at the expense of an expanded appreciation of societal interests. The offered justification, that therapists are merely giving clients what they want, may be countered by the argument that it is precisely the 'psy' society that has created these 'wants.'

Participants who adopt this less prevalent position do not label themselves as alternative therapy practitioners as such (except for the two participants who call themselves feminist therapists). However, the suggestion that therapists' power be used constructively for emancipatory ends, which incorporates some sort of social analysis, makes their views compatible with some of the alternative therapeutic practices discussed in Chapter I. Unfortunately, they are also similar to most of these alternative practitioners in failing to fully appreciate the significance of an expanded notion of societal interests. This failure mitigates against fully embracing this position as the ideal vehicle for emancipatory ends (critically understood).

To expand on this last point, narrowly focusing on clients' immediate relationships has a number of ramifications. For example, it hinders an in-depth analysis of the negative effects which results from the capitalist modes of production and consumption which pervade North American society. It fosters the continuation of unbridled capitalism and competition. It bolsters the typical North American response to these negative effects, that is to transform the universal desire for belonging to a non-competitive greater whole into a very personal desire for caring about one's immediate circle of family and friends (see Bellah et al., 1985).<sup>52</sup>

However, in defence of adopting liberal-humanistic ideology, one might also applaud the participants (those advocating both the more and the less prevalent positions) for their strong commitments to their clients. In fact, in emphasizing their clients' agency, they expose

an important gap in the critical literature. That is, explicit in many of the participants' comments is the belief that it is also emancipatory to take clients' wishes seriously, to help clients on their own terms, something which the critical literature tends to overlook. The critical literature tends to ignore the fundamental issue raised by client-centered therapy, that is, is it o.k. to make someone better?

With respect to this, one participant turns the critical perspective on its head. She says it is important but not sufficient to change the social structures if the people within the structures continue to treat each other poorly. She goes on to say: "You have to understand and change your internal make-up. [And] you could do them both at the same time. You don't have to naval gaze for ever, but can act at the same time (Lorraine, 848)."

Participants who espouse the less prevalent position also help demarcate the contexts where certain socially informed therapeutic practices might not be appropriate, something overlooked by the critique in Chapter I. For example, they mention length of therapy and client characteristics as important mediating variables. These participants realistically argue that incorporating a social analysis is more appropriate in longer term (as opposed to shorter term) therapy, especially for relatively 'fragile' clients.

Without losing sight of the above mentioned problems associated with their adoption of liberal-humanist ideology, it is important to recognize that participant contributions enrich our understanding of psychotherapy's relationship to society. The participants highlight some shortcomings of Chapter's I critique of mainstream practices. This critique, though not ignoring the needs of individual clients, underemphasizes the importance of respecting clients' power, and is too focused on the need to harness therapists' power. And as Prilleltensky and Walsh-Bower's (1992) moral imperatives make clear, it is incumbent for therapists to also respect their clients and their choices.

One reaches the same conclusion through the application of a Derridian Inspired analysis. That is, by revealing the meta-theoretical assumptions of both my particular reading of the critical literature as well as the participants' pronouncements, one concludes that each emphasises what is left unsaid by the other. That is, the participants' liberal-humanistic perspective, combined with a relatively narrow understanding of power leads them to underemphasise societal interests, while Chapter I's marxist-humanistic perspective, along with a Foucauldian/structural understanding of power, leads it to underemphasise the agency of clients.

As already alluded to, deconstructionism has the ability "to unsettle the theories which we surround ourselves and to gradually shift the structures within which we operate" (Sarup, 1989, p. 60). However, one must venture outside its confines to develop guidelines as to the next course of action (Sarup, 1989).

In choosing among the existing options, the dialectical perspective that focuses on the individual-society strand of the dialectic (discussed in Chapter I), appears to be a promising approach. This perspective's flexibility allows it to incorporate both the humanistic participants' concerns for the individual as well as Chapter I's Foucauldian/Gramscian analysis of society's ideological underpinnings. More concretely, this dialectical perspective appears capable of ensuring that clients are respected while at the same time promotes the well-being of society at large. Meeting both of these goals in this way mirrors Lather's (1991) use of a contradictory, doubled strategy, in that this perspective supports issues such as power and domination, while simultaneously stressing the agency of the fragmented subject. Relying on Adorno's (1966) understanding of negative dialectics has the added benefit of fulfilling Lather's criteria for producing knowledge that is "contested, incessantly perspectival and multiply-sited ... full of unresolvable tensions and necessarily partial" (Lather, 1991, p.49). That is, the tensions inherent in this version of dialectically-informed clinical practice are never fully resolvable.<sup>53</sup>

Most participants (that is, the 'the more prevalent position') do not perceive the dialectical give and take between their individual clients and the social world. For example, they do not conceptualize the individual as embodying society, nor do they conceive of the individual as reflecting societal values. They do not appreciate the practical social consequences of incorporating a social analysis in therapy. Most of them express their preference not to discuss socially relevant issues in therapy, believing them to be irrelevant to the client in the room. In addition, extrapolating from the data, most participants might believe that any conscious attempt at incorporating a social critique would be a misuse of their power. However, as already discussed, dialectically inclined therapists disagree with this assessment (Caspary, 1980, Efran et al., 1990, Gerber, 1990). To remind the reader, these therapists contextualize a social critique by asking clients for their social concerns. They argue that engaging clients in a social analysis, and reflecting on social issues that have universal importance is extremely relevant and opens up potentially productive investigatory pathways. Given this, therapists who unilaterally decide not to engage in these potentially productive avenues for analysis might themselves be accused of being patriarchal and disrespectful. That is, they would be assuming that all clients are incapable of rejecting the social critique, if they so choose.

The less prevalent position is more congruent with the dialectical perspective. Subscribers of this position attempt to integrate societal interests, albeit sometimes narrowly understood, with the interests of individual clients. In fact, they help demarcate the practical boundaries of socially informed therapeutic practices by offering concrete directions for implementation. For example, they argue for an expansion of practice to minority clients, suggest how therapists can help clients influence institutional systems, recommend a discussion of the social repercussions of clients' behaviour, and encourage the use of a societal analysis in therapy. Advocates of this position also warn that these methods might not

be suitable for all clients at all times. For example, they suggest that some adults who are particularly fragile and "who are elementary in their development" (Catherine, 772), as well as most children, are probably ill-prepared to comprehend an in-depth social analysis.

Advocates of the less prevalent position sensitised me to the importance of engaging in a contextual examination concerning the suitability of these methods, given the potential dangers that inhere in authoritative practices. However, acknowledging the potential dangers of incorporating societal interests does not preclude their inclusion. In fact, including an expanded understanding of societal interests beyond the participants' limited notions of the social is warranted. To repeat, psychotherapy has wide ranging societal effects, regardless of whether they are desired. Therefore, I believe that it is preferable to try to control rather than run away from these dangers. It is better to treat clients as co-interpreters of the meanings of their discourse and to present a variety of both social and personal interpretations, in the services of emancipatory therapy and of positive social change.

Gergen (1991) discusses the importance of assuming a multiplicity of viewpoints that allow for no right or wrong answers. Given mainstream psychology's shared reliance on psychologism, there exists only the appearance of choice between existing clinical theories. Assuming this alternative to psychology's myopic focus on 'the self,' the impact may be a heretofore unimaginable combination of different therapeutic practices. It may also help foster the development of a more ethically responsible profession, both in terms of individual clients and in terms of its relationship to society at large.

### Implications and Suggestions for Future Research

In this section, I will discuss a number of issues concerning these findings' transferability to other psychotherapists, mention some implications that this work has on emancipatory research practices, and indicate how this study enhances emancipatory

therapeutic practices. Throughout this discussion, a number of avenues for future research are suggested.

### Findings' Transferability to Other Psychotherapists

Insofar that this is an empirical study, relying on sampling techniques to obtain a cross section of participants, it is reasonable that one would want an indication as to degree of similarity between the presented themes and themes which might be generated by other practising psychotherapists. However, given grounded theory's explicit utilization of theoretical as opposed to random sampling techniques, and its privileging of the contextual nature of knowledge, the data are only meant to reflect the experiences of this sample of participants. The goal of the present research is not to generalize these findings, but to obtain rich data that are meant to have evocative power, and be meaningful to other practitioners.

In research employing grounded theory methodology, the concept of 'generalizability' is replaced by the concept of 'transferability.' The burden of proof for justifying the transferability of research results lies with the potential user. Transferability is always dependent on the degree of overlap between contexts, and is necessarily subject to disconfirmation or non-utility across different contexts (Guba & Lincoln, 1989; Lincoln & Guba, 1985). Since the present project employs grounded theory methodology, it must be left to other psychotherapists to determine the degree of representation or transferability of the presented material.

Having said this, after investing copious and copious amounts of time and energy in the present project, I am biased in believing that the themes are indeed representative of the discourses in which most psychotherapists generally engage. My bias is also supported by more inter-subjective criteria, such as the diversity of sampled opinions. For example, the sample contains a broad cross section in terms of a number of characteristics, including gender, political and sexual orientations, and therapeutic approaches. In addition, that the



participants report dealing with a wide range of clients, in terms of factors like gender, economic and social position, and presenting complaints, buttresses my case.

I am less willing to maintain that the themes represent any particular sub-group within the profession. This is due to my reticence in attributing special significance to the role of particular participant demographic factors in accounting for the specifics of the presented themes. Some reasons for this reticence are as follows: The themes are meant to be caricatures that do not necessarily represent the views of any particular participant, some participants hold conflicting ideas, and there are relatively few participants whose demographic profiles overlap.<sup>54</sup> With respect to this last point, even when participants share some characteristics, they often differ with respect to other potentially important demographic variables. This is especially pertinent when dealing with a relatively small sample size. For example, in the present sample there are only four gay participants, and in terms of this select group, two are men, two are women, two are psychologists, one is a social worker and one is a counsellor.

The participants' relative homogeneity in their tendency to be self reflective and self critical poses a further problem for one still intent on generalizing the results. I agree with the participant who believes that this study over-represents the number of psychotherapists who think about these issues, and that those who feel they have nothing to say chose not to participate (Cleo, 954). In fact, it would have been unethical, going against the dictates of emancipatory research, to try in any way to coerce or to manipulate others into participating. Therefore, the fact that the present sample is comprised of participants who want to articulate their analysis effectively limits this samples's ability to be representative of the beliefs of a more general population of psychotherapists. On the other hand, one could argue that this samples' composition with respect to this factor does not pose an insurmountable theoretical problem. Based on the present findings, one could logically assume that if a relatively self

reflective and self critical sample generally condone individualistic theory, then a sample of less critical and/or reflective psychotherapists would probably do the same.

The initial reasons for obtaining a diversified sample were to obtain rich data that represent a number of perspectives and to guard against the dangers of artifactual results, so that the themes do not simply reflect a restricted range of demographic characteristics. I believe that these purposes are met, the end result being a rich thematic presentation of therapists' views on therapy. I must however leave it up to the judgement of other practitioners to decide whether this sample is sufficiently diverse to make the findings transferable to their particular context.

To enhance the likelihood that similar studies be transferable, future researchers could target particular groups of psychotherapists sharing common characteristics, e.g., groups who are involved either in mainstream or in alternative type practices. For example, a researcher could target a group of gay, black or feminist therapists, or alternatively, focus on middle class therapists specializing in cognitive behavioural interventions. It might also prove interesting for the researcher to interview the clients of each of these groups of therapists, to examine the relationship between therapist views and the views of their clients. For example, it would be interesting to find out whether clients of feminist therapists conceptualize their issues in social terms. One could also examine whether these clients express feeling less oppressed in society, and appear to be more sensitized or conscientized to ideology and its role in creating their discomforts, compared to the clients of more mainstream therapists.<sup>55</sup>

To further develop our understanding of the contextual nature of the material, it might also prove interesting for a different researcher to use a similar questionnaire guide and analysis, and to interview these same participants as well as others. It might be especially interesting if the researcher had as much perceived power as the participants, and/or did not feel intimidated by the participants to agree with their views. A researcher who did not share

professional ties with her or his participants might feel less intimidated of the participants, and the participants might also feel less threatened if they perceived a critique of therapy as emanating from outside the profession.

Future research could also expand the study's frame of reference. For example, participants could be asked to comment on specific therapeutic approaches purporting to have a societal aspect (e.g., feminist therapy, deconstructionist informed therapy, dialectically informed therapy). This would help ground the specifics of the alternative perspectives.

Other groups besides psychotherapists and clients could be employed as research participants. Other related professionals could also be interviewed, e.g., medical doctors. An interesting twist would be interviewing people who chose not to pursue a career in psychology precisely because of these issues, such as some sociologists (whom I know, for example). It is acknowledged that this group of people might have a predisposition to be biased against the psychological profession. However, this fact should not exclude them from participation. The present participants were most likely predisposed to favour present psychological practices, due to a desire to justify their own life choices.

Interviewing people from different cultures might also prove interesting. They are in a position to supply a number of unique perspectives, standing outside of the 'psy' society. In fact, a participant who has been involved with different cultures gave me this idea. He says:

I've come to question it, in more recent years I think, by seeing other social ways of being ... And living in a lot of different places, with different senses of community and family and so on. And, seeing that identity can be socially, interpersonally defined, not individually defined. And those people can be just as happy, possibly happier, I don't know ... When you have lived in two or more cultures, you can see the differences. (Ross, 622)

### Implications For Emancipatory Research

This research is emancipatory in that it reveals the ideological implications of psychotherapeutic practices, examining the role of power in the exercise of such practices. It is emancipatory vis a vis the participants in helping them engage in an examination of the ideological underpinnings of their work. This research encourages the participants as well as other psychotherapists reading these words to rethink fundamental values. This research could be considered especially meaningful in encouraging relatively powerful people (members of the psychotherapeutic community) to engage in these self-reflexive processes.

In line with emancipatory inquiry, participants were afforded the opportunity to think about and discuss their reactions to this inquiry, a process that is sorely lacking in most traditional questionnaire and survey research. The research is also consciously self-reflexive, formally acknowledging how the researcher's own interests in emancipatory therapy might have effected the presentation of the participants' perspectives. A number of safeguards were built-in to guard against this eventuality. Evidence attesting to the safeguards' success is a number of reader declarations that the thematic presentation does not appear to be tainted by the critique presented in Chapter I.

This project raises an interesting question concerning the desirability of engaging in emancipatory research on the powerful as opposed to the powerless. When dealing with powerful participants, it underscores the general tension inherent in using emancipatory means (such as paying special attention to honouring the integrity of participants' words) to attain certain emancipatory ends (such as revealing the workings of hierarchal power structures in society). That is, it points to the difficulty of both respecting and criticizing the discourses of powerful people in society. Hence, perhaps my reticence to forcefully challenge or criticize these powerful participants. In the present research this tension was particularly acute since I presumed the participants to be especially powerful vis a vis the researcher, that

is, myself (discussed above). In future research, it is worth exploring whether similar dynamics occur where the research participants are not perceived to be more powerful vis a vis the researcher. However, whether this strategy will be successful in overcoming the more general tension between respecting and being critical of the same participants is unknown.

Even if this tension proves to be unbridgeable does not mean that people engaging in emancipatory research should be loathe to represent sympathetically the discourse of the 'powerful.' As Lather (1991) admonishes, researchers should not privilege the critical elements of the emancipatory project if that effectively means controlling the objects of their study. Instead, those engaging in emancipatory research should be self-reflexive of their own project, and guard against the dangers of Marxist hegemony inherent in conceptual over-determinism.

Other potential avenues for future research include developing even more participatory practices, by engaging research participants in an analysis of their own pronouncements. There is a trade off between doing a systematic reading of the transcripts versus getting feedback from the participants. If a future researcher has more time and resources, he or she could ask participants to interpret their own words, and/or to comment on the researcher's particular reading. To expedite the process, a summary of their own words and/or a composite of the generated themes could be presented to them instead.

I did not go back to the participants to obtain their reaction to the thematic presentation. However, indirect evidence that the participants' words were not unduly manipulated to serve my own purposes comes from the comments of certain committee members. They felt that, if anything, I presented the participants' words and the surrounding text in an overly sympathetic fashion, that I did a good job preserving the integrity of the voices that are different from what they perceive to be my preconceptions.

### Implications For Emancipatory Therapy

One may interpret the participants' perspectives as grounding Chapter I's critique of mainstream therapeutic practices, and as lending support to the further development of emancipatory therapy. That there exists real practitioners who adopt 'the more prevalent position' helps ground the critique's understanding of mainstream practices. That there exists real practitioners who adopt 'the less prevalent position,' criticizing mainstream's exclusive focus on the individual, lends further justification to the critique. Finally, some of the participants help develop emancipatory therapy, saying that it is insufficient to acknowledge society's structured hierarchy, reminding us also to respect clients' expressed interests. The participants have enriched Chapter I's definition of emancipatory therapy by pointing to some of its limitations, and by helping explicate and contextualize some of the practices associated with the doing of this form of therapy.

An important implication of this project is that further development of emancipatory therapy depends on more than mere recognition of power. How one conceptualizes power is also important. The fact that most participants acknowledge their power while simultaneously believing it unimportant to consider its macro social effects suggests that reflecting on power does not necessarily lead to emancipatory therapeutic practices. It can also lead to client-centred, individualistically oriented practices. For the development of emancipatory therapy, therapists not only must identify their institutional position in society, but they also must be exposed to more structural notions of power, and be aware of its wide ranging, social implications. Without this awareness, liberal-humanist therapists might inadvertently be upholding the less savory elements of the societal status quo.

If therapists maintain a strict liberal humanist point of view, without accepting and incorporating this alternative understanding of power along with the problems associated with society's hierarchal power structures, then their practices will not change. To repeat one

participant's admonition: If one believes that there is nothing wrong with society, then there is no need to question the status quo. A therapist would aspire to be a social change agent only if he or she believes that society is in need of change (Lorraine, 874).

Practitioners cannot randomly choose to follow certain socially inspired practices and not others and be considered emancipatory therapists. For example, practising emancipatory therapy entails doing more than just having a number of clients who belong to minority groups. How one works with these clients is also crucial. One must guard against being an agent of state power structures who coopts minority clients and subjects them to even more oppression. An emancipatory therapist should not be afraid of discussing with these or any other clients concepts such as power differentials in society and its affects on clients' lives.

The dictates of emancipatory therapy behooves therapists to incorporate into their work the particular cultural factors that impinge upon their clients' lives, especially those factors that may not be part of their own experiences. For example, they should be aware of and sensitive to the power of children, to the different experiences associated with being gay or straight, to being rich or poor, and to being a man or a women in our society. Emancipatory therapists have to listen carefully to what their clients are saying. They must try not to interpret their clients through their own power position within the hierarchial structure of society.

In terms of suggestions for future research, there are a number of ways to further develop the critique of mainstream practices, against which emancipatory therapy is situated. For example, one can historically trace the implications of psychotherapy practices. More specifically, one can study whether more people over time present themselves as ill, whether there is an increasing stigmatization of people who are not functioning normally, whether there is a more pervasive extension of what 'normality' is, and whether the definition of 'normality' has expanded or contracted. Related issues include studying whether and/or how our society has become more individualistic as we appear to be losing a collective sense of ourselves,

and how this all compares to other societies that have a different ideological base and that do not practise our forms of psychotherapy. Extending the critique through these investigatory avenues has important consequences for the practices of emancipatory therapy.

In a more applied vein, the present findings form the basis for educating practising psychotherapists and those involved in training programs about the relationship between psychotherapy and society. The practical consequences of educating psychologists in particular (compared to social workers) about these issues are quite evident. For example, at present, psychologists' work and training isolate them from the social service community. Relying solely on psychotherapeutic techniques, they neither know nor think about how social service agencies can help their clients with very real social issues. With more formal consideration of the relationship between psychotherapy and society, clinical psychologists would be in a better position to help clients with their very real concerns.

Consideration of these issues might encourage practising psychotherapists to broaden psychotherapy's scope, to extend it fundamentally beyond the psychotherapeutic conversation. For example, most participants, though clear that clinical psychology should not concern itself with social change, maintain the desirability to affect social change outside therapy. For them, this does not signify the expansion of therapy to include other forms of community based interventions. Rather, such interventions are seen to take place outside the confines of therapy (e.g., as professors, in public speeches, etc.). From an emancipatory perspective, such interventions would be considered important. In addition, for those more sympathetic to developing emancipatory therapy practices per se, an interesting avenue to follow up on would be an explicit attempt at integrating community based interventions with psychotherapy.

Given the economic times, it might also be wise for therapists wishing to adopt an emancipatory perspective to become better acquainted with community psychological interventions per se (e.g., Bloom, B.L., 1984; Levine & Perkins, 1987; Newburgh, 1980;



Sarason, 1974). The participants' caveats concerning context are relevant here. That is, the participants suggest that a socially inspired analysis might not be appropriate in short term therapy, especially for 'fragile' clients. Given the serious funding issues surrounding the delivery of longer term service existing in most mental health settings, the most damaged people in our society who are often quite 'fragile,' might therefore not fully benefit from the perspective of an emancipatory psychotherapist. In such situations, to fulfil an emancipatory agenda, perhaps psychotherapists need to expand their work interests to include other forms of community intervention.

At the end of Chapter I, I outlined a number of principles meant to guide the development of emancipatory therapy practise. For example, I suggested that therapists explicitly reflect on their values and the social implications of the choices they make in therapy. I cautioned them against employing mainstream psychologistic explanations, instead suggesting that they offer clients an analysis of the societal causes of powerlessness, privileging a critical understanding of ideology. I proposed that this and other interventions be carried out in a collaborative spirit, that supports the potential emergence of alternative constructions of reality.

Elaborating on the practical import of these principles, many participants make a number of significant contributions to this emerging critical framework. Among their important recommendations for implementation are: 1) directions for expanding therapy practice to minority clients, 2) suggestions on helping clients influence institutional systems, 3) recommendations on discussing the social repercussions of clients' behaviour, and 4) examples on using a societal analysis in therapy. They also help identify some practical limits of an emancipatory therapy approach. For example, they mentioned length of therapy and client characteristics as important mediating variables. They realistically argued that

incorporating a social analysis is more appropriate in longer term (as opposed to shorter term) therapy, especially for relatively 'fragile' clients.

The participants' suggestions concerning the use of a relatively micro-level societal analysis in therapy is somewhat inconsistent with a major tenet of emancipatory therapy, as here prescribed. That is, most of them do not recommend the incorporation of a critical understanding of ideology in psychotherapy work. However, their counsel to maintain a strong commitment to the client in the room points to a potential oversight in the previously iterated principles meant to guide the development of emancipatory therapy practice. Their admonitions highlight the previous underemphasis on respecting the capacity of clients to select their own goals and to defend their own interests. Fortunately, the dual goals of respecting individual clients and incorporating a more explicit examination of macro-level power structures in society can both be accomplished by relying on Adorno's dialectical perspective. To remind the reader, this perspective ensures that clients are respected while at the same time promotes the well-being of society at large. Conforming to this perspective allows the therapist to have a co-equal responsibility to both the individual client and to society at large.

To conclude, this project can be used as a springboard to jump start a reflexive process, to make explicit and to start questioning the ideologies underlying psychotherapeutic practices. In incorporating both a critical perspective and the views of those who are intimately involved in the process of psychotherapy, the present research provides a well rounded analysis of the topics. Modifying this as a teaching instrument could lead to greater self-reflection within the profession. A more personal wish is that this project leads to more socially informed clinical practices, and ultimately to proactive actions that foster the well-being of both clients and the entire community.

## ENDNOTES

1. Any regular reader of a daily newspaper or news magazine, or watcher of 'Larry King Live' or of the many popular day time television talk shows (e.g., 'Phil Donahue,' 'Oprah,' 'Geraldo,' and in the Canadian context, 'Shirley') can attest to this recent explosion of media attention.

2. It is recognized that, for the most part, clinical psychology is not of one ilk. For rhetorical purposes, I beseech the reader to tolerate certain generalizations in discussing various features within mainstream psychology.

3. In discussing clinical psychology, the main focus of the paper is on psychotherapy practice. However, it also makes brief reference to the assessment enterprise.

4. Even clients who are members of, or identify with, an elite strata of society could benefit from an awareness of how systemic oppressive forces operate. As will be seen from the subsequent discussion, no one is immune from the ravages resulting from a capitalist and consumerist society.

5. At this point, it is appropriate to clarify and scrutinize my own value system, and offer some personal musings concerning my interest in the issue of social responsibility. My value system which serves as the basis for encouraging my fellow psychotherapists to engage the status quo and to affect certain changes on a social scale (e.g., in the redistribution of the wealth and resources in our society) is congruent with a marxist-humanistic perspective. I interpret this perspective as honouring and respecting individuals' choices while simultaneously taking into account the societal power structures that fundamentally affects everybody's ability to make choices.

What is my place in the social order that I am writing a critique of therapy? Most traditional psychological professionals, with their middle class training, education and income, are part of the very class which their work tends to support (Sullivan, 1984). Though I share some of these characteristics with other psychologists, perhaps my value system, my Jewish education that stressed the importance of questioning everything, and the relative freedom I enjoy as a student, are sufficiently distinguishing factors.

I tend to feel that this work somehow reflects a rebellious streak. However, these actions are also informed by an alienated and alienating society, which on the level of my chosen profession has witnessed a proliferation of publicly exposed therapist abuses.

Another possibility: Is my socially informed desire to critique the existing order less noble in intent, e.g., Am I jumping on the postmodernist mainstream bandwagon, and hoping to ride it to a successful career? Danziger (1990) suggests that the kinds of questions considered legitimate determines what is to be studied. Previously, the question of the political effects of psychotherapy was not considered legitimate. In the rush to apply postmodern thought to just about everything, it is conceivable that in a few short years interdisciplinary study, e.g., relating politics and psychology, might become all the rage. Without perspective, it is difficult to choose. Maybe the important point, though, is to just pose the questions.

6. Hunt (1987) defines psychotherapy as the type of therapy (either short or long term) in which psychologists, psychiatrists, social workers, family and couples therapists, and pastoral counsellors are engaged.

7. Alternatively, one can hypothesize a hierarchy of world views, in which certain individuals see their own views as being superior.

8. In Discipline and Punishment, Foucault (1977) chronicles the emergence of the "norm" and its replacement of the "law" as the primary instrument of modern social control.

Whereas an earlier regime had produced a knowledge of overt action [crimes or sins] and a power whose target was bodies, the new regime sought to know and to discipline character, or the 'soul.'... The human sciences investigated the laws governing the formation, perseverance, and alteration of sensibility. They produced character typologies and classifications of "souls."... Once the laws governing a particular [type] were known, prescriptions for altering it could be devised.... From the standpoint of social control, the relevant categories ceased to be the old-fashioned juridical ones of guilt and innocence. Instead, they became the social science ones of normality and deviancy. Henceforth, the world came to be populated less by malefactors than by "deviants," "perverts," and "delinquents." (pp. 44-5)

9. Rothalzer (1979) also discusses the necessity for therapists to examine their societal roles in order to better serve the client in the room:

Clinical psychologists do not want to consider themselves advocates of the system at the expense of being advocates of their clients, yet without an understanding of the macro-sociological and political aspects of intervention, many practitioners may inadvertently fall into this role. It is posited here that clinical psychologists... must continually struggle with their roles in a societal context and examine the values underlying their interventions. This is necessary both to provide optimal service to individuals and to facilitate the ability of psychology as a whole to reduce human suffering and promote human welfare. (p.718)

10. Richardson (1993) argues that philosophic liberalism or liberal individualism is the disguised ideology of explanatory social science. He says that this view portrays human behaviour as radically self-interested, and it obscures how people are co-participants in cultural enterprises.

11. Assuming previous knowledge on the part of the reader, and discussing metatheoretical issues only in so far as they concern psychotherapy's impact on society, it is acknowledged that this paper offers only a brief, unbalanced view of logical positivism. For an excellent critique of logical positivism, see Barratt (1984, pp. 32ff).

Commenting on a similarly brief sketch of logical positivism in a recent article by Hare-mustin and Marecek (1988), Walkup (1989) takes offense at what he labels 'cruel distortions' sketched by the hostile opponents of logical positivists. Walkup suggests that a more balanced reading of the proponents of positivistic thinkers such as Carnap and Neurath, would unearth a form of constructivist thinking uncanny in its resemblance to their critics' thinking. For example, he suggests that

By the 1930s, Carnap believed that judgements of truth were relative to a framework, that the choice among frameworks could not be based on correspondence to reality, and consequently, that the decision on which framework to adopt must be based on expedience, fruitfulness, and other pragmatic considerations, considerations similar to those advanced by Hare-Mustin and Marecek, in their section titled "The Question of Utility" (p.1331).

For the purposes of the present paper, a charge of incompleteness was deemed less important than whether the paper encourages critical thought,

challenges entrenched assumptions, and helps in advancing knowledge in psychology.

Hare–mustin and Marecek (1989) furnish another argument in favour of brevity. In discussing interdisciplinary issues that go beyond psychology's limited barriers (e.g., philosophical concerns such as different metatheoretical perspectives), they state:

It does not follow that a full exegesis on every influential thinker can or should be provided.... If that were the requirement, interdisciplinary work would stop, and all scholars except those working in small and arcane fields would be silenced. (p.1334)

12. The report on the Boulder conference is written up in Raimy (1950).

13. As Danziger (1990) comments:

The social acceptance of their expertise required that psychologists legitimate their claims in terms of certain widely accepted criteria, which were based on prevailing conceptions of the scientific method.... The methods had to be seen to be rational, which, ... meant that they had to bear the hallmarks of science. (p.119)

14. A further illustration of the close relationship between practice and marketability concerns psychotherapy's association with the assessment enterprise. Sarason (1981a) relates how the psychological profession, after World War II, eagerly agreed to join psychiatry in developing a new public mental health policy. They hoped that through the process of association, psychologists would be afforded some of the prestige already bestowed on the psychiatric profession. Therefore, in accordance with psychiatry's wishes, they agreed to focus their energy on developing assessment skills, thereby limiting their research contribution. Again, this decision has theoretical repercussions. Developing critical social theory, and taking social issues seriously, significantly undermines the choice to concentrate on assessment, an approach predicated on the belief that intra–psychic processes are much more important than social considerations in understanding human behaviour.

15. MacIntyre (1984) agrees:

The therapist treats ends as given, as outside his [sic] scope; his concern is with technique, with effectiveness in transforming neurotic symptoms into directed energy, maladjusted individuals into well-adjusted ones. The therapist is not able to engage in moral debate. He sees himself, and by those who see him with the same eyes as his own, as an uncontested figure, who purports to restrict himself to the realms in which rational agreement is possible –that is, of course from his point of view to the realm of fact, the realm of means, the realm of measurable effectiveness. (p.30)

16. To repeat a previous quotation: Psychology "replaces violence and force of arms with the 'gentler' constraint of uninterrupted visibility" (Fraser, 1989, p. 23).

17. Laing, later on in his career, disliked being reminded of his status as a spokesperson for the 60s generation. He considered his radicalness as an aberration, as a sign of the times (Sedgwick, 1982).

18. O'Hara (1989) relates the story of an encounter group in which Carl Rogers participated. Supposedly, a woman in the group wanted to discuss the male–female power dynamics in the group. Rather than using this question as a springboard for social critique, the incident culminated in a very private individual experience.

Rogers responded to her by asking her to express how she was experiencing her own "personal power" in the group at that moment. Gradually the focus shifted from "How come the men seem to be in charge here?" to "How can I get closer to Carl?" and finally culminated in a cathartic release as the young woman acknowledged a deep frustration in her attempts to get close to her father. (pp.20–21)

19. That some of these alternatives have much earlier origins is indisputable. For example, modern feminist approaches to therapy claim roots in the earlier feminist critiques of the 1920s and 1930s. These early criticisms were based on the notion that women's 'neuroses' stemmed from a sick, male dominated society (Castel et al., 1982). What is being suggested here though is that the development of theoretical sophistication and popular acceptability are relatively recent phenomena.

20. Examples of how feminist therapists have encouraged their clients toward social, political, and economic action are provided by Radov, Masnick and Hause (1977), Rawlings and Carter (1977), and Thomas (1977).

21. Parvin and Biaggio (1991) identify a number of therapeutic issues that may conflict with feminist theory. These potential conflicts include empowerment of individual choice versus adherence to 'the politically correct choice,' maintaining clear boundaries versus joining with the client, and acting in the best interest of clients versus sacrificing clients' interests for the good of the community. They maintain that successful strategies for overcoming these conflicts have not yet been developed.

22. Cushman (1993) agrees, arguing that many social constructionist therapists, especially those who work with families, are lacking a critical bent.

23. Given the complexity of this topic, I quote Kurtzman (1987) at length, as he discusses Derrida's understanding of the relationship between the sign, the signifier and the signified:

The signifier never subsists alone, but is always the result of its differences from that which it is not. The signified, further, does not lie external to the system of differing signifiers but is instead a result, a development, of the signifying system itself. For there is no signified that is graspable directly; a signified exists only in so far as it is represented. Reality –some pure, un–represented being or presence– cannot even be thought except through signification, because thought itself is signification. The signifiers, which classically were conceived as deriving their identity –their "meaning"– from the signifieds, are now seen to determine, through the system of signifiers to which they belong, the particular signifieds that supposedly exist. And so the classical notion of the sign is overturned. Samuel Weber has written: 'The difference is not one of representation between sign and the thing referred to, not one within the sign, i.e., between signifier and signified: rather it becomes a principle which generates signifier and signified as such.... The notion of signification is no longer thought of as representation, but rather as

articulation' (Quoted in Nagele, 1979, p.21). It is the pure difference, which supports any signifier system, that is primary and underlies any concept of a pure, unified, simple presence. Difference is not then just a secondary, derivative property holding between signifiers, as classical thought held. (p.43)

24. Anthony Graziano, a clinical psychologist at the State University of New York, Buffalo, speculates that some clinicians try to convince large numbers of people that their minor anxieties might be symptoms of deeper and more severe problems. He asks: "Might we not, in effect, be mobilising our social power to convince more and more persons that they are mentally ill?" (Graziano, cited in Gross, 1978, p.42)

25. In addition, an analysis of White's (1993) presentation of a number of case studies reveals a similarity with the humanistic goal of restoring individual 'essence.' That is, the purpose behind helping clients understand the social basis of their self-presentation is for them to reclaim their sense of self.

26. I am assuming that critical social science is somewhat compatible with social constructionism, in that the former builds on the latter by adding in an analysis of power relations. However, it is acknowledged that some commentators have theorized a different relationship between these two approaches. For example, Schwandt (1990) describes some of the differences between the social constructionist and the critical social science approaches as follows:

If the constructivist methodologies are preoccupied with the restoration of the meaning of human experience, then critical science methodologies are pre-occupied with reduction of illusions in human experience. (p.268)

Others have argued more forcefully that critical social science is fundamentally opposed to the constructionist tradition (e.g., Popkewitz, 1990). Alternatively, some commentators believe that there is an inherent tension between the two, though they can co-exist in a paradoxical relationship (Riley, 1988).

27. Unlike some brands of constructionism, critical social scientists do not privilege individual experience. On the contrary, most of these loosely related like-minded thinkers reject the concept of 'essence,' a fundamental thing-in-itself, "with its claim of a natural defining core for persons and things" (Tress, 1988, p.196). This position is suspicious of any individual who claims that she/he is able to define an experience completely free from illusions.

28. A further example of this approach is Caspary's (1980) attempt to integrate both radical and conventional therapies. He emphasizes the importance of not throwing conventional knowledge out the window when incorporating a social critique.

In a dialectical process the goal is not the elimination of one position by the other, but a fruitful tension through which both are eventually transformed" (p.33; Also see Sherman, 1976; Sipe, 1986).

29. Terry (1993) makes a similar argument. She says that feminist informed therapists impose values on their clients (egalitarian values), though traditional therapists also impose values, albeit of a different kind.

In addition, closer examination of Barratt's (1984) perspective lends support to the notion that his value system informs his own work. For example, his own non-identitarian thesis, that contradictions inhere in all experience, that perfection of any sort, including a perfectly value neutral stance, is impossible, supports the notion that values must inhere in

therapy. In addition, the proof that Barratt offers to verify that unconscious processes or desires have entered the semiotic system, is none other than his own value system, informed by personal experience. As he (1984) says, "You have to be in psychoanalysis to really appreciate it" (p.263). Furthermore, in carrying out his psychoanalytic practice, he depends on some traditional psychoanalytic conceptions, such as 'transference.' Within the strict confines of his attempt at neutrality, it is arguable that the understanding of the client's experience from such pre-existing theoretical frameworks might abrogate the reappropriation of the pre-semiotic contents of the unconscious.

30. Aside from this criticism, there are additional reasons for moving away from positivist methodology. The heart of positivist methodology, and the key to its success, is its ability "to artificially separate processes into elements for temporary study out of context" (Bidell, 1988, p.331). However, serious consequences inhere in this reductionistic approach.

On the personal level, an artificial separation of elements by those who are statistically preoccupied contradicts a rich examination of individual phenomenon. For those reductionists, individual existence is meaningful only insofar as it is measurable. Giorgi (1970) has labelled this narrow preoccupation with the dubious philosophical subscription 'measurement precedes existence.' With respect to the present research project, reducing individual expression to statistical form would be especially damaging, given the desire that the participants have the opportunity to express their views in ways which they see fit.

On the societal level, positivist research decontextualizes intricate relationships. It suppresses variability and contradiction, writing off these processes as being merely bias and distortion. However, decontextualizing intricate relationships opposes a significant aspect of the substantive argument. That is, therapists' opinions concerning their relationships with society cannot be studied acontextually, since they are situationally embedded in larger systems. With respect to the second point, the suppression of variability camouflages an important feature of social life, that is, the notion of variable discourse (Potter & Wetherell, 1987). Furthermore, logical positivist research usually ignores power issues, or 'reduces' them until only the minutia is left (Hollway, 1989). This contradicts the main gist of the preceding argument, that was to privilege issues of power.

More generally, a key criterion of logical positivist driven research is parsimony. This goal appears to make sense when one's intent is to make quick probabilistic predictions. However, given that the aim of this research is to obtain 'a richer understanding,' parsimony loses its esteemed place (see Kurtzman, 1987). To repeat: Employing a methodology that aims at decontextualizing phenomena would contradict the very fabric of the substantive argument, that the therapeutic enterprise must be analyzed within its societal context. Given the above critique, it appears that this research project would be better served by employing an alternative set of methodological strategies that privileges meaning over measurement, and that celebrates rather than suppresses contradiction.

31. To repeat Lather's understanding of emancipation and empowerment, discussed at the beginning of chapter 1: Her perspective resists reducing the application of these terms to acts of individual self assertion, or to the experience of feeling powerful. Rather, her use of these terms includes facilitating the process of individuals choosing their own course of action, based partly on their analysis of the societal causes of their powerlessness. Such an analysis would include the recognition of the ideological underpinnings in society.

32. Lather (1991) explains her reluctance to develop research practices that depend solely on the subject's presentation of self. She says that such accounts are conditional:

People's accounts are contingent: upon available time and discourses (the regimes of truth which govern the directions in which one's thinking can go);



upon the relationships within which the accounts are produced and upon the context of events recounted; upon power and the defences in operation against formulating different versions because of their self-threatening implications. (p. 39)

Others have presented similar arguments. For example, Hollway (1989) argues against the idealist notion that language is transparent, that words refer unproblematically to things, and can be represented in individual accounts. Such an idealist approach neglects the impact of power relations on the production of discourse. It runs counter to the idea that "people's subjectivities are produced within discourses, history and relations" (p.41). In a related vein, Marxists similarly critique the meaningfulness of subjective accounts, arguing that such accounts obscure the workings of false consciousness (e.g., see Lather, 1986).

33. The interpersonal realm has a cultural component that may remain non-conscious in any one particular setting. The term culture here refers to knowledge, attitudes and habitual behaviour patterns, shared with significant regularity by some members of a particular segment of society. This knowledge does not necessarily represent a unified corpus of ideas or behaviour. Therefore, this cultural component is understood as being contested, temporal, and emergent (Burgess, 1984; Clifford & Marcus, 1986; Jacob, 1987; Thomas, 1993).

34. Examples of client characteristics are mentioned in chapter III.

35. Thomas (1993) endorses this flexible approach: "The danger of beginning an interview with a list of questions 'written in stone' is that the list becomes a crutch that hobbles the researcher in pursuing data" (p.40; also see Bryman, 1988; Burgess, 1984; Lincoln & Guba, 1985; Stones, 1985).

36. However, I did supply a copy of the questions to two participants who requested it prior to the interview. One of these participants, in fact, gave what I perceived to be "textbook responses," though the other one did not.

37. The reader is welcome to consult with me if he or she would like access to any of the raw data (i.e., the interview transcripts, or the initial levels of analysis). Due to the confidential nature of the material, one is only permitted controlled access to parts of the data.

38. For example, participants' reasons for becoming therapists made interesting reading, but was dropped as a theme since it was mostly irrelevant in light of the other themes. Another example concerns the treatment accorded to the information regarding the humanistic orientation of most participants. I first conceived of this as a major theme. It was later collapsed and used as an explanatory device for therapists' respect for the power of their clients.

39. Osbeck (1993), who also argued that a pragmatic standard be used as the criterion for social constructionist research, defines pragmatic research as research that is potentially useful to society. In order to be useful to society, Osbeck says that the research must have generativity. Quoting Gergen (1982, p.109), she describes generativity as

The capacity to challenge the guiding assumptions of the culture, to raise fundamental questions regarding social life, to foster reconsideration of that which is "taken for granted" and thereby to generate fresh alternatives for social action. (p.342; also see Hollway, 1989; Lincoln & Guba, 1985; Van Vuran, 1989)

Research that meets these criteria would be fulfilling most of Lather's (1991) criteria for critical research, as described at the outset of this chapter.

40. In an interesting twist, Billig (1985) applies the dialectical strategy to the process of categorization itself. He suggests that in order to categorize, one must at the same time partake of its opposite process, that is, to particularize. For example, he says that:

An inflexible use of categorization will necessitate flexible particularization.... Categories do not exist in isolation, but a category, if it is to be applied, must be particularized or selected from other categories. As such it is conceivable that an inflexible use of one category might necessitate a flexible use of other categories, and in this way a rigid categorization would not lead to further rigidities but to subtle particularizations. (p.93)

41. In the presentation of themes, it should be remembered that the opinions or options expressed by the participants within some sub-themes are meant to represent composite sketches. Therefore, adherence to different opinions or options are not necessarily mutually exclusive. That is, the same participant may favour more than one option. However, it is safe to assume that the opinions of most participants were consistent within each option.

42. To indicate their level in the hierarchy, each theme, sub-theme, sub sub-theme, etc., is identified with a system of prefixes, corresponding to the system used in Table 1 (Taxonomy of Themes).

43. With respect to 23 out of 24 participants, pseudonyms are used in order to protect their anonymity. The 24th participant (Souhail) explicitly requested that his real name be used. A number of participants requested that a particular pseudonym be used to represent them. I chose standard English names to represent the remaining participants.

The bracketed numbers, appearing with the direct and indirect quotations in this chapter, refer to the original numbering scheme used to identify the meaning units (refer to analysis section for an explanation of 'meaning units'). The numbers are presented here in order to make the audit trail evident.

44. The awkward phrasings 'the more prevalent position' and 'the less prevalent position' are used to indicate that some participants do not neatly fall into one of the two categories. A few participants are ambivalent, in that their views contain elements of both points of view.

45. This list is presented in a group format to protect the anonymity of the individual respondents.

46. In addition, it would be inappropriate to use statistical means to measure the degree of association between the particular participant characteristics and attitudes concerning the impact of therapy on society, given the small number of each sampled characteristic.

47. Again, the themes can be legitimately characterized as caricatures, in that they represent a number of perspectives, with which no one participant is expected to be in full agreement. Therefore, the phrase "the participants' pronouncements" should be understood in the collective sense.

48. Two participants took the opportunity to make major changes. The majority of them requested only a few grammatical changes or no changes at all.

49. The chairperson, Henry Minton, closely supervised these procedures, particularly the process of incorporating the themes across participants into a multi-level scheme of themes. His participation was not only invaluable but is further testament to the claim that appropriate procedures were used throughout the analysis.

50. Given the quantity and richness of presented data, numerous interpretations are possible. It is expected and welcomed that some readers will focus on different aspects of the relationship between the thematic presentation and the critique.

51. Paradoxically, the only time that most liberal-humanist participants consider it appropriate to act as if clients' choices were wrong, and to exercise their own power in telling them this, is when they believe that clients' choices do not conform to liberal-humanist ideology. For example, most participants believe it appropriate to tell clients to make their own decisions, regardless of clients' expressed wishes that someone else (e.g., the therapist) make the decisions for them (see Mark, 1984 in the section titled 'Therapy is Client Driven').

However, it is not always easy for therapists to decide whether abiding by their clients' wishes means that they are conforming with liberal-humanist ideology. For example, this rule of thumb might be insufficient for the therapist who is faced with a client's expressed wish that he or she be left alone to commit suicide. The difficult question is whether the therapist would be respecting the client's long term wishes by honouring their short term wish to die.

52. In addition, if the empowerment process is not grounded within a larger framework, then helping a client feel more powerful might be harming someone else. For example, assuming that society is a zero sum game, then helping a client gain more confidence so that he or she gets a job means that another person does not get a job.

53. Adopting dialectical theory does not authorise one to arbitrarily pick and choose when and where to care for the client or to analyze the ideological underpinning in society. Complying with the dictates of dialectical theory, that is, to self consciously keep the tension between these conflicting elements alive, is not synonymous with engaging in a relativistic free play of meaning. These actions may appear relativistic and seemingly arbitrary only when judged by objective epistemologies that stake their legitimacy on accepting the existence of ultimate truths (Barratt, 1984; Gavey, 1989; Gergen, 1991; Lather, 1991).

54. An additional reason why the themes are presented as caricatures is: To further ensure anonymity, a number of participants were promised that their words would not be presented by themselves as an integral whole, but that the material would be presented in a group format. It was believed that a group presentation would make it more difficult for the reader who is previously acquainted with a participant(s), and who is intent on engaging in some detective work while reading the transcripts, to identify any particular participant(s).

55. A sceptic might interpret a positive result as reflecting the clients' new found ability to frame their issues in terms of oppression and emancipation.

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**APPENDIX A: RECRUITMENT STATEMENT****A PARTICIPATORY STUDY  
OF THERAPISTS ATTITUDES OF  
PSYCHOTHERAPY'S IMPACT ON SOCIETY**

Dissertation Research

Researcher: Peter Cobrin, M.A.

Chairperson: Henry Minton, Ph.D.

Many psychotherapists have wondered whether psychotherapy has, or should have, an impact beyond the immediate concerns and issues of "the client in the room". Most therapists hope that the effects of therapy generalise beyond the therapy relationship, though it is debatable what this should mean. For example, some have questioned whether therapists should exclusively commit themselves to helping their individual clients, or whether in their direct work with clients, they should also consciously work towards constructively changing the lives of others, or maybe even society at large. Another concern that has been debated in the literature is whether the ethical responsibilities to individual clients and society conflict, and if they do, then which takes precedence.

Rarely have psychotherapists been directly consulted for their views on these important issues. To help fill this obvious gap in the literature, I am hereby requesting practising therapists to offer their opinions about these matters in a relatively unstructured interview, which should last approximately one hour. In a subsequent interview, therapists will have the opportunity to comment on my representation of their views as well as to help analyze the views of other participants, who will remain anonymous (All responses will be held in strict confidence). Even if therapists are available for only one interview, their participation is still welcome. After the study is completed, I can provide a summary of the perspectives which have emerged during the interviews.

There are many benefits which may be gained from taking part in this innovative "participatory" project. For example, it could provide: the occasion to make a substantial contribution to a new field of research; the chance to personally grapple with some important concerns which have broad implications; the occasion to further one's professional growth; and the opportunity to help a grateful graduate student fulfil his program requirements.

I thank you for considering this appeal. If you would like to participate, or would like any additional information, you can contact me (Peter Cobrin) through the University of Windsor, at (519) 253-4232 (Ext. 2217), or at (519) 973-1230. Please leave a message and I will get back in touch with you. Hopefully, I can make arrangements to meet even if you live outside of the Windsor area, because I would like to have a broad basis of participation.

**APPENDIX B: PARTICIPANT INFORMATION FORM**

Department of Psychology  
University of Windsor

**A PARTICIPATORY STUDY OF  
THERAPISTS ATTITUDES ABOUT  
PSYCHOTHERAPY'S IMPACT ON SOCIETY**

Dissertation Research  
Researcher: Peter Cobrin, M.A.  
Chairperson: Henry Minton, Ph.D.

The purpose of the current research is to generate a multiplicity of perspectives concerning psychotherapy's impact on society. It is especially concerned with ethical dilemmas which psychotherapists face in their everyday practices. This research should result in a richer understanding of the relationship between psychotherapy and society.

If you agree to take part in this participatory project, you will be interviewed (once or twice, depending on scheduling availability) and asked to talk about some practical choices you have made while working with your clients that might have social implications. You will also be asked to furnish some background demographic information. In a second interview, you will be asked to comment on my interpretation of your perspective, as well as to help analyze the views of other participants, who will remain anonymous (Your responses will also be held in strict confidence).

Throughout the interview process, a relatively unstructured format will be used. You will be encouraged to discuss the issues that you feel are most important, and to not answer, or to digress from any particular question, as you see fit. There are no "right" or "wrong" answers to any of the questions; simply be as honest as possible about your perspectives. Completing each interview should take about one and a half hours. These interviews will be audio taped for transcription purposes and subsequently erased. All identifying information will be deleted from the transcripts. The transcribed responses will be identified only by a research code number, and will be held in strictest confidence. When this study is completed, you will be able to obtain, on request, a summary of the research findings from Peter Cobrin, Department of Psychology, University of Windsor.

This study has been cleared by the Ethics committee, Psychology Department, University of Windsor. Any concerns or questions about this research may be directed to myself, to Dr. Henry Minton, Department of Psychology, to Dr. Robert Orr, Head, Department of Psychology, or to Dr. Ron Frisch, Chair, Ethics Committee, Department of Psychology, University of Windsor, N9B 3P4, (519) 253-4232 ext. 7012.

## APPENDIX C: CONSENT FORM

I understand that I may withdraw from the study at any time for any reason, at my request.

I understand that my identity will be kept strictly confidential. I realise that my name will never be used in connection with the study nor in any report of its findings, now or in the future.

I agree to permit my responses to be used anonymously in any publications which may result from this study. I realise that excerpts of my responses may be subsequently cited verbatim, understanding that the source of these excerpts will be kept strictly anonymous.

I have read both the recruitment statement and the participant information forms. I understand the description of this study and agree to participate in the research procedures as outlined. I have been given an opportunity to write in below any changes, limitations or restrictions with this statement.

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DATE \_\_\_\_\_

NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_

**APPENDIX D: SAMPLE INTERVIEW GUIDE #1**  
(prior to participant #1)

These questions are intended to serve as a preliminary guide in exploring individual psychotherapist's views on the relationship between the role as psychotherapist and the workings of society. They are meant to be applied by each respondent personally, in their own work, as well as in relation to their understanding of the profession as a whole.

**THERAPISTS WILL BE ENCOURAGED TO TALK ABOUT THEIR WORK EXPERIENCES AND HOW THESE EXPERIENCES RELATE TO THEIR THEORETICAL BELIEFS. THEY WILL BE ASKED TO FURNISH REAL EXAMPLES FROM THEIR ENCOUNTERS IN THERAPY.**

**1) Personally, what do you think are the main goals in therapy? (Common goals, for most clients)<sup>1</sup>**

-are there common goals which you have for most clients **EXAMPLES**

-do some of these more general goals change depending on which "group" the client identifies with, e.g., women, gays and lesbians, people from different cultural backgrounds, the unemployed **EXAMPLES**

**2) What are some of the major changes you would like to see in society? Might this be related to the way in which you work with your clients, or to your goals in therapy? How?**

-Maybe we should try to impart a certain morality to our clients or maybe we do, whether or not we are conscious of it (More cynically, one might say that we might try to convince our clients to think the way we do). What do you think about this? **EXAMPLES**

-Do you find it easier to work with certain like-minded people, with whom you have really good rapport **WHO, EXAMPLES**

-Is there a certain class of clients with whom you have particular difficulty working with **WHO, EXAMPLES**

-would you work with a killer, a rapist, a thief, a petty thief? What would the goals of therapy be in such situations? Might the end result conflict with some greater good?

**3) Do you believe that an appropriate goal in therapy is to "make the world a better place to live"?**

-what might this mean **EXAMPLES;**

-is there a tension between this and your obligation to the client in the room **EXAMPLES**  
(Discuss therapeutic successes and failures, maybe in terms of how your clients end up relating to others)

(For me to keep in mind:

-is it within your realm as a psychologist to think about, and to try to implement or develop a "good or moral" society **EXAMPLES**

-what is your definition of "the good or moral society," "the good life", "the common good"

(probe to see if its centre is the autonomous individual, and/or if it includes a social component)

-what are your politics outside of therapy; do they get played out within therapy; **EXAMPLES**

-do you believe that therapy is a political act, do you see your work as political, and if so, then how so, and if not, explain

[having a political agenda ties into other issues such as therapist as teacher or expert, and the issue of power])

**4) Do and should you introduce social issues in therapy**

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<sup>1</sup> The underlined statements are the initial questions. The following statements are probes.

–Do you have special approaches when dealing with different groups in society, e.g., women, gay and lesbians, unemployed people, people with different cultural backgrounds EXAMPLES?

(For me to keep in mind:

–which levels of analysis do you employ in therapy (individual, family and friends, immediate context [therapist–client], community, societal); how do they get played out)

5) Do you like to think of yourself as someone who is a social change agent? Inside of, and/or outside of therapy? How do you see this as related to "social responsibility"? How would you define therapists' social responsibilities?

–are there other intervention strategies (outside of therapy) you engage in, or would like to engage in (public talks, community activities, etc.) – are these related to your self–concept of psychotherapist

–might you try, want, to have an impact on people who don't generally come to therapy (because of "class" or whatever)

(For me to keep in mind:

–how would you define society (different levels, e.g., spouse, family, community, country, continent, species, etc.)

–regardless of intentions, does (should) therapy contribute to the larger social world; how; is the contribution neutral, negative or positive;

–do you have any particular ethical or moral obligations with respect to the workings of society; are you obliged to work towards the betterment of society; how would you define this obligation; What are one's ethical commitments to the community; to society;

–does your social obligations conflict with your obligations to the client in the room; how EXAMPLES; do the norms of the society/community nurture or constrain these obligations

–are the social responsibilities as expressed in the Codes of Ethics, and as is generally practised, sufficient; are they different from our general ethical responsibilities – how

6) Do you like to think of yourself as an agent of emancipation or empowerment

–how would you define emancipation [e.g., emancipation for whom, and what is the substance of the emancipatory project]

–are people in need of emancipation

–would you define your work as emancipatory; even if you don't, might someone else define your work as such

7) I'm wondering if you would mind commenting on your original motivations for wanting to become a psychotherapist: (I guess that you might have changed your mind somewhat since then?)

–probe to see if there was a social component; specific issues, situations from the past which might have been instrumental; specific social issues, personal anecdotes

–have you met your goals EXAMPLES

–if there has been a change in direction, why

8) Do you think that your views on training clinical psychologists are affected by these political/social issues?

9) What do you think about the theory that individual therapy helps perpetuate the structural conditions which help create the problems about which clients complain. For example, by offering individual solutions to problems which might have a social basis, it has been suggested that psychotherapy might be diverting attention away from seeking social solutions.

and might be helping legitimise "so-called" dehumanising practices of large institutions, and bureaucracies.

10) Might there be other issues or questions that would have also been useful to talk about? Are there any comments or concerns about what we did talk about?

**APPENDIX E: SAMPLE INTERVIEW GUIDE #2**  
(prior to participant #5)

–It might be strange for the therapist to do most of the talking

\*\*\*–Think about your own work, as well as the profession as a whole. If possible, please discuss real examples from your work, so that we do not end up talking only about theory

\*\*\*–expand on the issue of confidentiality (would you prefer your own name to be used) opportunity to edit this next week if you would like.

\*\*\*–generally: whether, and if so, how values get played out in therapy, and if therapists should consciously let their values shape their work, especially in terms of the values we hold in relation to the workings of society

\*\*\*–I have some strong views which might come out during the interview; however, there is no hidden agenda here; the goal of this interview is to hear what you have to say, since most of my understanding of these issues come from books, from theory, and are not really grounded in practice: I am asking for your input in helping flesh out these ideas, from the practitioner's viewpoint

\*\*\*–We might be pressed for time as we have lots to cover. I would like you to answer as fully as you possibly can, but please try to not feel offended if I suggest that we go on to another topic.

Some demographic questions:<sup>1</sup>

–clinical experience

–setting within which you work and categories of practices (e.g., those who deal with both adults and children, either privately or in institutional settings),

–preferred clientele

–types of psychotherapy training — do you still use the same approach

\*\*\*\* –1) theoretical approaches in doing therapy 2) Do you use explanatory schemas in your work. If so, then which levels of explanation would you use say that you most often utilise. (For example, those on the molecular level, on the level of brain-behaviour, intra-psychically, interpersonal (family, friends), societal level, etc.); how might they relate to the type of "treatment" which you offer (examples) — do you share these schemas with your clients?

\*\*\*\*\*3) Do you see your therapist role partly as an educator?

1) Personally, what do you think are the main goals in therapy? (Common goals, for most clients)

–are there common goals which you have for most clients; do you think that your clients have common goals? EXAMPLES

–Do you notice whether clients who identify with certain groups have particular concerns in therapy which seem to be common in that group? e.g., women, gays and lesbians, people from different cultural backgrounds, the unemployed EXAMPLES

–Do you find it easier to work with certain people, with whom you have really good rapport WHO, EXAMPLES

–Is there a certain class of clients with whom you have particular difficulty working with WHO, EXAMPLES

–would you work with a killer, a rapist, a criminal, a petty criminal? What would the goals of therapy be in such situations? Might the end result conflict with some greater good?

–would you mind discussing the cultural/ethnic groups or other reference groups which you might identify with —might this impact on your response?

2) Do you believe that your values influence the goals in therapy, or how therapy gets played out. If so, then how?

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<sup>1</sup> The underlined statements are the initial questions. The following statements are probes.



Do you believe that therapists (OR YOU) impart a certain morality to clients whether or not they are conscious of it; that is, might therapists be subtly manipulating clients in a certain way.

-What do you think about the idea that there are 1000s of choice points in therapy, and that the therapist (as well as the client) chooses which choice points to pay attention to, and what to do at that choice point? (Do, how do you help frame the issues in therapy)

More demographics

- social philosophies (e.g., liberal, conservative, marxist, whatever)
- political affiliations or leanings
- previous familiarity with issues of domination, power, ideology, etc.

3)What are some of the major changes you would like to see in society? what is "society": related to the goals or the process of therapy?

-\*\* from the original Recruitment statement: comment on:

1) Re- what does it mean for the effects of therapy to generalise: Some have questioned whether therapists should exclusively commit themselves to helping individual clients, or whether in their direct work with clients, they should also consciously work towards constructively changing the lives of others, or maybe even society at large.

\*- Do you believe that an appropriate goal in therapy is to "make the world a better place to live"? EXAMPLES -regardless of intentions, does therapy contribute to the larger social world, i.e., make the world "better"

4) WHAT YOU SHOULD DO Should therapists impart a certain morality? EXAMPLES Do you believe that values should influence therapy

what do you think about the idea that therapists do "social engineering", whether it is intended or not -either toward a particular social change model, or maybe to uphold the status quo

-SHOULD YOU, within your realm as a psychologist think about, and try to implement or develop a "good or moral" (def.) society EXAMPLES

-do you have any ethical or moral obligations with respect to the workings of society; are you obliged to work towards the betterment of society, meaning?; What are one's ethical commitments to the community; to society;

\*\*\*-ex.: client is abused (their story? reality?); should therapists actively support, encourage, suggest the possibility of criminal charges? maybe for the greater good, and not primarily for the good of the client?

5) Do you like to think of yourself as someone who is a social change agent? Inside of, and/or outside of therapy? How do you see this as related to "social responsibility." What is "social responsibility?" What should therapists' social responsibilities be?

-are there other intervention strategies (outside of therapy) you engage in, or would like to engage in (public talks, community activities, ADVOCACY, etc.) - are these related to your self-concept of psychotherapist

-might you want to have an impact on people who don't generally come to therapy (because of "class" or whatever)

-do you think your politics get played out in therapy? If asked, do you think that your clients would know what your politics are?

-does your social obligations ever conflict with your obligations to the client in the room; how, which takes precedence? EXAMPLES; do the norms of the society/community nurture or constrain these obligations

-do the social responsibilities as expressed in the Codes of Ethics, and as practiced represent your views

6) Do you feel that concepts such as empowerment play a role in therapy? what about emancipation?

-how would you define emancipation [emancipation for whom, and what is the substance of the emancipatory project, are people in need of emancipation

-would you (or someone else) define your work as emancipatory

7) Do you think that your views on training clinical psychologists are affected by these political/social issues?

-how would you prioritise and rate what we should be teaching therapy students: neuropsych, intrapsychic theories (such as traditional psychodynamic theories), interpersonal theories, sociological theories,

8) I'm wondering if you would mind commenting on your original motivations for wanting to become a psychotherapist: (I guess that you might have changed your mind somewhat since then?)

-probe to see if there was a social component; specific issues, situations from the past which might have been instrumental; specific social issues, personal anecdotes

-have you met your goals EXAMPLES

-if there has been a change in direction, why

9) What do you think about the theory that individual therapy helps perpetuate the structural conditions which help create the problems about which clients complain, that it helps support the system from where it comes. How do you understand this question

10) where do you see therapy fitting into society? Or your brand of therapy? Do you see it fitting in somehow, in some global sense? Is therapy a political act?

11) Might there be other issues or questions that would have also been useful to talk about? Are there any comments or concerns about what we did talk about? Could you suggest another therapist who holds different views from your own who might be appropriate for this study?

12) Do you believe that your perspective represents the views of "most" clinicians? Do you feel you have a sense of what other therapists think about these issues?

## APPENDIX F: SAMPLE INTERVIEW GUIDE #3

(prior to participant #9)

-It might be strange for the therapist to do most of the talking

\*\*\*-Think about your own work, as well as the profession as a whole. If possible, please discuss real examples from your work, so that we do not end up talking only about theory

\*\*\*-expand on the issue of confidentiality (would you prefer your own name to be used) opportunity to edit this next week if you would like.

\*\*\*-I have some strong views which might come out during the interview; however, there is no hidden agenda here; the goal of this interview is to hear what you have to say, since most of my understanding of these issues come from books, from theory, and are not really grounded in practice: I am asking for your input in helping flesh out these ideas, from the practitioner's viewpoint

\*\*\*-We might be pressed for time as we have lots to cover. I would like you to answer as fully as you possibly can, but please try to not feel offended if I suggest that we go on to another topic.

Some demographic questions:<sup>1</sup>

-clinical experience

-setting within which you work and categories of practices (e.g., those who deal with both adults and children, either privately or in institutional settings), socio-economic status of clients

-preferred clientele

-types of psychotherapy training — do you still use the same approach

1) Do you believe that your values influence the goals in therapy, or how therapy gets played out. If so, then how?

-What do you think about the notion that therapists are, or can be value neutral? Do you believe that you are? (Would asking someone "How did you feel when...?" be an example of the therapist remaining neutral, or might it somehow legitimise the action that the client is describing?)

-[How] does your values impact on the direction that therapy takes?

-Do you believe that therapists (OR YOU) impart a certain morality to clients whether or not they are conscious of it; that is, might therapists be subtly manipulating clients in a certain way.

-What do you think is the relationship between your own values, and the values which inhere in psychotherapy, as you understand it?

2) Do you believe that therapists are powerful?

-How?

-Individually, as a group; inside or outside of therapy.

3) THEME: Therapy focusing on the individual and/or on society

-Do you use explanatory schemas in your work. If so, then which levels of explanation do you use most often, e.g., those on the molecular level, brain-behaviour, intrapsychic, interpersonal (family, friends), societal; how might this relate to the type of "treatment" which you offer (examples)? do you share these schemas with your clients?

-Do some or all of your clients seek therapy for what you perceive to be completely, or partially, a "social problem"? (e.g., might clients be depressed because of the economic situation)

-What is the role of the client's external reality in therapy?

-Do you notice whether clients who identify with certain groups have particular concerns in therapy which seem to be common in that group? e.g., women, gays and lesbians, people

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<sup>1</sup> The underlined statements are the initial questions. The following statements are probes.

from different cultural backgrounds, the unemployed EXAMPLES (WOULD AN AFFIRMATIVE RESPONSE MEAN THAT THE THERAPIST IS "CONTROLLING" AND ISN'T RESPECTING THE DIGNITY OF THE INDIVIDUAL?) Would you see differences or patterns along traditional diagnostic category lines?

–would you mind discussing the cultural/ethnic groups or other reference groups which you might identify with —might this impact on your response?

–does your practice change with changes in society? How? (Probe– recession? sexual abuse? "false" memory stuff)

More demographics

–social philosophies (e.g., liberal, conservative, marxist, whatever)

–political affiliations or leanings

–religious beliefs

–What do you see as important values which our society promotes? Would you like to see any changes in the values which are generally promoted?

4) How would you define psychotherapist's social responsibilities?

–probe to see whether a therapist's ethical responsibilities to society are equivalent to his or her legal responsibilities.

–Psychotherapeutically speaking, are there any special responsibilities associated with the most disadvantaged groups or individuals in our society?

–Should therapists try to make the world less racist, less sexist, less anti-semitic.

–do your social obligations ever conflict with your obligations to the client in the room; how, which takes precedence? EXAMPLES; do the norms of the society/community nurture or constrain these obligations

–do the social responsibilities as expressed in the Codes of Ethics, and as practiced represent your views

\*– Do you believe that an appropriate goal in therapy is to "make the world a better place to live"?

–what might be our ethical or moral obligations with respect to the workings of society; (How) are we obliged to work towards the betterment of society? to implement a "good" or "moral" society? (examples)

–Regardless of intentions, how does therapy contribute to the larger social world, i.e., make the world "better," "worse," or leave it as is.

5) Do you like to think of yourself as someone who is a social change agent? Inside of, and/or outside of therapy?

–Do you see your therapist role partly as an educator?

–comment on Original Recruitment statement: What does it mean for the effects of therapy to generalise? Some have questioned whether therapists should exclusively commit themselves to helping individual clients, or whether in their direct work with clients, they should also consciously work towards constructively changing the lives of others, or maybe even society at large.

–are there other intervention strategies (outside of therapy) you engage in, or would like to engage in (public talks, community activities, ADVOCACY, etc.) – are these related to your self-concept of psychotherapist

–might you want to have an impact on people who don't generally come to therapy (because of "class" or whatever)

–Do you make a distinction between so called "pure" psychotherapy, and the aspect of social work which is more "social" or active?

–do you think your politics get played out in therapy? If asked, do you think that your clients would know what your politics are?

6) Theme: Imparting morality to clients

-Do you sometimes suggest to clients to do something in a particular way, because you believe that their way of doing things might be inappropriate or maybe even harmful

-Ex.: Have you worked with a killer, a rapist, a criminal, a petty criminal? What would the goals of therapy be in such situations? Might therapy conflict with some greater good? Do people commit crimes because they are victims of society?

-\*\* Ex.: Would you tell a husband who was battering his wife that what he is doing is wrong? How would you express this, and how might this be related to the question of either unintentionally or wanting to impose values?

\*\*\*-ex.: client is abused (their story? reality?); should therapists actively support, encourage, suggest the possibility of criminal charges? maybe for the greater good, and not primarily for the good of the client?

-what do you think about the idea that therapists do "social engineering", whether it is intended or not —either toward a particular social change model, or maybe to uphold the status quo.

7) Do you feel that concepts such as empowerment play a role in therapy? what about emancipation?

-how would you define these terms [emancipation/empowerment for whom, what is the substance of the emancipatory project, are people in need of emancipation]

-would you (or someone else) define your work as emancipatory

-can or does an emancipatory process have any content? Is it working towards something, towards some vision of social justice? (How) does that play itself out in therapy? Is the idea to partake in a process where choices are opened up, or should it include particular choices (e.g., to discuss the possibility of the client taking some social actions, such as participating in demonstrations).

8) Do you think that your views on training clinical psychologists are affected by these political/social issues?

-how would you prioritise and rate what we should be teaching therapy students: neuropsych, intrapsychic theories (such as traditional psychodynamic theories), interpersonal theories, sociological theories.

-Do you feel that your own training was somehow deficient, e.g., with respect to gay and lesbian issues, feminist theories, theories about violence against women, economics, the effects of capitalist exploitation, different cultures.

9) I'm wondering if you would mind commenting on your original motivations for wanting to become a psychotherapist: (I guess that you might have changed your mind somewhat since then?)

-probe to see if there was a social component; specific issues, situations from the past which might have been instrumental; specific social issues, personal anecdotes

-have you met your goals EXAMPLES

-if there has been a change in direction, why

-are there inappropriate reasons for someone wanting to become a therapist, e.g., to "rescue" others (what might that mean)?

\*\*\* Would living in a third world country have affected your career choice (would that have affected your ability to feel fulfilled as a therapist)

\*\*\* Are you particularly interested in helping people who are disadvantaged or downtrodden? If yes, then why, and how might you accomplish this?

10) (How) should we aim to change the practice of therapy?

11) What do you think about the theory that individual therapy helps perpetuate the structural conditions which help create the problems about which clients complain, that it helps support the system from where it comes. -Explain my understanding: that the "structure" teaches people to be individualistic, to be aggressive, to compete, to only look after themselves, which

causes lots of problems (leaving people without a sense of community, and feeling adrift in this competitive world). And then therapists help people get over their problems by again focusing on the individual to look after themselves better.

–Do you believe that a therapist who takes a codependency approach or an approach which says that problems stem from early childhood, is helping support the system? Do you take these approaches?

–Does therapy help legitimise so-called dehumanising practices of large institutions?

–What do you think about the idea that therapists divert resources from the social to the individual realm?

12) Might there be other issues or questions that would have also been useful to talk about?

Are there any comments or concerns about what we did talk about? Could you suggest another therapist who holds different views from your own who might be appropriate for this study?

13) Do you believe that your perspective represents the views of "most" clinicians? Do you feel you have a sense of what other therapists think about these issues?

### Vita Auctoris

Peter Cobrin was born to Ruby and Gertrude Cobrin on September 5, 1960, in Montreal, Quebec. In 1977 he graduated from Herzliah High School in Montreal. He received his Bachelor of Arts degree in Political Science in June, 1982 from the University of Toronto, and his Master of Arts in Psychology in June, 1990 from the University of Windsor.