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Negotiating a pathological identity in the clinical dialogue: Discourse analysis of a family therapy

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Within the framework of social constructionism, psychotherapy has been re-conceptualized as a semiotic process, which consists of the creative generation of new meanings in the context of collaborative discourse. In recent years, research approaches that draw from social constructionism, such as discourse analysis, have been fruitfully employed in the study of psychotherapy processes, whilst being in line with the contemporary emphasis on language, narrative, and meaning making. This paper aims to further the exploration of the usefulness of discourse analysis in the study of psychotherapy processes, and in particular, in situations where the medical discourse is powerfully implicated in the construction of a person's identity. It is based on the analysis of a family therapy with a family whose child has a diagnosis of autism. The analysis focuses on two features of the family's talk, namely shifts in the flexibility of employment of a diverse range of discourses and subject positions, and shifts in the ways agency is constructed and discursively negotiated in the clinical conversations. It is suggested that these shifts can be used as indications of change in the family's network of meanings. The analysis suggests that an important aspect in clinical work with families with a member with a psychiatric diagnosis lies in decentring, or deconstructing, the dominant, pathology-maintaining accounts, and allowing for a wider range of less problematic narratives and subject positions to emerge.

In recent years, it is being increasingly acknowledged that qualitative research provides a useful alternative to quantitative research in the study of psychotherapy processes (e.g. McLeod, 2001; Toukmainian & Rennie, 1992). This reflects a more general shift towards qualitative research, a shift largely fuelled by the postmodernist critique of positivism, as well as the orientation of contemporary psychotherapy towards a more

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reflexive ideology and practice. More specifically, within psychotherapy approaches that draw from the 'shared consciousness' of social constructionism, there has been a move towards developing research approaches that are (a) epistemologically compatible with their theoretical underpinnings, (b) theory-based and clinically meaningful, in order to reduce the gap that exists between clinical research and actual practice, and (c) actively deconstructive, that is, committed to a critical stance towards taken-for-granted knowledge and to a process of analysing and problematizing the naturalization of particular discourses, with a special focus on how these are enshrined in institutional practices (Frosh, Burck, Strickland-Clark, & Morgan, 1996; Harper, 1995; McLeod, 2001). From a social constructionist viewpoint, notions such as the self, psychopathology, psychiatric diagnosis, and psychotherapy are defined as interactional and primarily language-based processes, and so discourse analysis becomes an appealing candidate for their study.

Social constructionist conceptualizations of the self are organized around a critique of 'traditional' psychological theories and argue that the notion of self-contained individualism is culturally biased, as well as epistemologically and ethically problematic. In social constructionist and post-structural approaches, subjectivity is conceptualized as dynamic, relational, multiple, and contextual, constituted through language and historically situated linguistic practices, and there is a tendency to emphasize the more fleeting, incoherent, and fragmented aspects of identity (e.g. Edley, 2001; Henriques, Hollway, Urwin, Venn, & Walkerdine, 1984). This view of the self also permeates many recent conceptualizations of psychotherapy, which emphasize the role of language, narrative, and meaning-making in the evolution and dissolution of psychological problems (e.g. McLeod, 1997; McNamee & Gergen, 1992). Therapy is conceptualized as an essentially semiotic process, a productive discursive practice, which consists of the creative generation of new meanings in the context of collaborative discourse (Kaye, 1999). Accordingly, the therapist's role has been described as that of a 'master conversationalist' or a 'friendly editor' (Anderson & Goolishian, 1988). 'Dysfunction' tends to be associated either with extreme rigidity in the use of a limited repertoire of discourses and subject positions, with the resultant silencing of vital aspects of experience and subjectivity, or with chaotic incoherence in the use of the various subject positions of the self. Consequently, the aim of therapy is seen to be the reduction of dissociation and/or the increase of coordinated flexibility in the use of various aspects of subjectivity (Georgaca, 2001). Based on the Foucauldian view that new discourses make new possibilities visible and new practices possible, it is assumed that new accounts of the self permit the generation of new, less problem-saturated self-experiences (Guilfoyle, 2002).

Although there now exists a relatively large body of social constructionist literature on psychotherapy (e.g. Fee, 2000; Parker, 1999), this work tends to be theoretical and the actual discourse analyses of psychotherapy sessions published to date are few. For example, in a recent literature review on qualitative research in family therapy, only 10 of the 24 studies identified drew from social constructionism (Gehart, Ratliff, & Lyle,

2001) and, McLeod (2001), in his recent book on qualitative research in psychotherapy, referred to only two discourse analytic studies, only one of which involved the analysis of actual sessions. Although these reviews are not comprehensive, the numbers cited are indicative of the dearth of discourse analytic research on actual transcripts of psychotherapy sessions. Moreover, it is perhaps not surprising, given the shared theoretical basis in postmodernism and social constructionism of discourse analysis and systemic therapy, that the majority of the published discourse analytic studies of psychotherapy sessions concern systemic therapy (e.g. Guilfoyle, 2002; Hare-Mustin, 1994; Kogan, 1998; Kogan & Gale, 1997; Kogan & Brown, 1998; Roy-Chowdhury, 2003; Soal & Kottler, 1996; Stancombe & White, 1997) with a few exceptions of individual psychotherapy (Ferrara, 1992), psychoanalytic/psychodynamic therapy (Finlay & Robertson, 1990; Lewis, 1995; Madill & Barkham, 1997; Madill & Doherty, 1994; Nye, 1994), feminist psychodynamic therapy (Burman, 1992a, 1995), group therapy (Vandewater, 1983; Wodak, 1981), and cognitive-behavioural therapy (Messari & Hallam, 2003).

One discursive characteristic of the clients' talk that has been investigated in several discourse analytic studies of psychotherapy concerns the flexibility with which clients employ a wide range of discourses and subject positions. It has been suggested that shifts in the flexibility of discourse use and the diversity of subject positions occupied are associated with therapeutic change. For example, in two discourse analytic studies of systemic therapy, it was claimed that family members moved from being firmly aligned to one discourse regarding a central theme discussed in the therapy, to deploying several discourses flexibly at the end of therapy and this shift was regarded to be associated with positive change (Burck, Frosh, Strickland-Clark, & Morgan, 1998; Frosh *et al.*, 1996). A similar hypothesis has been put forward in two further studies concerning how problems evolve and dissolve in families (Dallos & Hamilton-Brown, 2000; Dallos, Neale, & Strouthos, 1997). It was suggested that the formation of a pathological identity is a recursive process, which involves a narrowing of the repertoire of available narratives and the dominance of problem-saturated meanings, which are typically associated with the medical discourse. Similar points were made in discourse analytic studies of individual psychotherapy. For example, Madill and Barkham (1997) explored the client's deployment of different subject positions, during the process of brief psychodynamic-interpersonal psychotherapy, and postulated a relationship between the capacity to position oneself in a wider range of subject positions and psychological improvement. Similarly, in a constructionist analysis, which traced the deployment of different subject positions in a long-term psychodynamic psychotherapy, Georgaca (2001) suggested that therapy should aim to enhance the fluent interplay of various subject positions including a reflexive 'I'. Furthermore, a similar argument, regarding the importance of the availability and flexible deployment of various discourses, can be drawn from discourse analytic studies, which focus on the permeation of psychotherapy by culturally powerful discourses (which imbue both the clients' and the therapists' talk), their potentially constraining function and the possibilities for their deconstruction in the context of the

clinical conversations. A number of hegemonic discourses have been investigated from this perspective, for example culturally bound versions of subjectivity, individualism and agency (e.g. Burman, 1992; Burman, 1995; Guilfoyle, 2002; Kogan & Gale, 1997), gender, gender roles and relationships (e.g. Burman, 1992; Burman, 1995; Hare-Mustin, 1994; Kogan, 1998; Madill & Barkham, 1997; Madill & Doherty, 1994), family relations (e.g. Madill & Barkham, 1997; Soal & Kottler, 1996), 'civilization' and culture (e.g. Roy-Chowdhury, 2003; Soal & Kottler, 1996). From this perspective, such culturally preferred ways of constructing reality are seen to be implicated in the creation, maintenance, and dissolution of psychological difficulties. It can, therefore, be argued that the investigation of the ways these discourses are negotiated within actual therapy sessions is a useful focus of analysis in psychotherapy research. It is, however, noteworthy that discourse analytic investigations of the way pathological identities are constructed, maintained or dissolved within therapy talk specifically with regards to psychiatric diagnosis are missing from the relevant research literature.

A second issue, which has been explored in discourse analyses of psychotherapy talk, relates to the construction and negotiation of agency in the clinical dialogues. Agency refers to notions of motivation, involving incentive and the initiation of action, and intention, which refers to the direction of that action. In most psychotherapeutic approaches, the self-narratives that are considered to promote psychological well-being are those that involve the notions of personal agency and self-definition, in line with the notion of self-contained individualism (Rose, 1998; Sampson, 1993). For example, in the study by Burck *et al.* (1998) it is suggested that the discursive repositioning of the mother as someone who is in charge, in a family presenting with parenting difficulties, is seen to be associated with therapeutic change. This tendency towards constructing agency and self-containment as ideal has been demonstrated analytically to operate in the actual practice even of constructionist therapies, which on a theoretical level endorse a critique of self-contained individualism (e.g. Guilfoyle, 2002; Madill & Doherty, 1994).

The current study aims to explore further the above features, that is, fluidity in discourse use and the discursive negotiation of agency, as they relate specifically to situations where a psychiatric diagnosis exists, that is, in situations where the medical discourse is powerfully implicated in the construction of a person's identity.

More specifically, it focuses on the analysis of a systemic therapy with a family whose child was diagnosed as autistic/psychotic. An important assumption underpinning this work is that the available discourses are not all equal in their power and that some are more hegemonic or unitary, that is, they assume the status of fact and they are considered as true and accurate descriptions of the world (Turner, 1995). The medical discourse, and psychiatric diagnosis in particular, has been shown to be a powerful hegemonic discourse that functions to determine criteria of normality, to define asymmetrical subject positions for those implicated in the clinical encounter, and to define what is valid knowledge, who has access to it, how this knowledge can be communicated and to whom (Samson, 1995). Furthermore, the medical discourse conceals its constitutive power by appealing to images of truth, scientific objectivity,

clinical effectiveness, and unambiguously benevolent intentions, legitimizing, in this way, medical power and the practice of medical institutions (Keen, 1997). An important implication of the psychiatric diagnosis is that it objectifies the person diagnosed, provides subject positions that are constraining, pathologizing and disempowering, and limits the person's freedom to position him/herself in relation to alternative discourses (Sampson, 1993). Moreover, when referring to a child, the pathologizing and constraining effect of the diagnosis has implications not only for the child but also his/her parents, through the prevalence of the discourse of normal development, which associates children's difficulties with parental failure, fault or pathology, and through the implication of culturally-held beliefs regarding the 'good family' (Burman, 1992b; Phoenix, Woolett, & Lloyd, 1991; Urwin, 1985).

In short, psychiatric diagnosis is an example *par excellence* of a powerful discourse, which on the one hand limits the range of possible understandings of the problem, and on the other hand represents psychological difficulties as located 'inside' the individual, constructing a pathological identity and thus stripping the person of their agency. It can, therefore, be argued that analysing the conversations around psychiatric diagnosis, within the context of actual therapy sessions, will shed light on the discursive work involved in deconstructing a hegemonic discourse, which implicates notions of normality, deviance, stigma, development, and, in the case where the 'identified patient' is a child, parenthood. This seems a particularly relevant focus in systemic process research, given that one of the central clinical tasks in systemic therapy relates to the transformation of the presenting problem from an individual, intra-personal view to an interpersonal, relational, or systemic one (Sluzki, 1992). Such an analysis becomes more salient in light of the fact that there are no discourse analytic studies focusing on the discursive negotiation of a diagnostic label within actual therapy sessions.

The current study

The therapy referred to in this paper consists of 12 sessions of systemic family therapy, drawing primarily from the Milan model, which took place in a community mental health centre in Greece, over a period of a year with a frequency of approximately one session per month. As with similar discourse analytic studies, it was selected for analysis as an example of a therapy where both the family and the therapist felt that significant positive changes had been achieved. In line with the centre's usual practice, all the sessions were tape-recorded and consent was obtained by the family for the use of the transcribed material for research and teaching purposes, provided that their anonymity was preserved. The principal therapist has over 15 years' experience in systemic work, and the researcher was a member of the family therapy team.

The family consists of the father John (37), the mother Anne (35), and their child Tom (3,5). The family self-referred to the centre because of their concern about Tom's

development; he had previously been diagnosed as autistic, psychotic, and learning-disabled by different professionals. The family's initial request was to clarify Tom's 'real nature'. Repeated readings of the session transcripts followed by a thematic analysis of their content, that is, an initial coding through identification of the main themes discussed in each session, suggest that the course of therapy can be broadly described in terms of two phases. The first phase, which forms the object of this study, centred on the negotiation of the nature of Tom's problems and his identity, issues that had important implications for the construction of the parents' identity. The second phase focused primarily on the parents' relationship and its meaning within the context of their relationships with their respective families of origin.

All the sessions were transcribed and analysed employing discourse analytic methods. Discourse analysis involves a particular reading of texts, which takes a functional perspective on language and which focuses on the ways in which speakers draw from culturally available explanatory frameworks to construct the objects about which they speak and an array of subject positions (Edwards & Potter, 1992; Parker, 1992). In other words, talk is analysed with a focus on the functions it has within the specific interactional context in which it is produced, and the analysis aims to investigate the discourses on which speakers draw from, the versions of reality they construct, and the subject positions they deploy. The analysis is presented here in relation to a small number of extracts, which were selected as representative examples of the main analytic claims pursued in this paper. More specifically, the analysis focuses on shifts in the multiplicity and flexibility of discourses employed by the parents in talking about themselves and their child, and in the way Tom's identity is constructed, particularly with regard to agency. In line with other studies, it is assumed that such changes in the way important themes are talked about are clinically significant indications of change in the family's network of meanings (Burck *et al.*, 1998; Dallos *et al.*, 1997**. Frosh *et al.*, 1996). It is acknowledged that a number of different points could be made regarding the extracts presented here, and that each analytic reading creates some possibilities for understanding, while at the same time, marginalizing, to some extent, alternative readings.

The Foucauldian notion of the 'centre', as it has been applied to descriptions of the unfolding of talk in psychotherapy, has been useful in this analysis. The 'centre' represents singularity and hegemony of one dominant discourse; it is the story being told, whereas the margins refer to the story left untold. Employing the metaphor of the centre, the postmodern therapist's conversational agenda (i.e. the consistent pattern of effects she has on the evolving discourse) has been described as 'decentring' the unfolding narrative, both at a local level and at the level of its embeddedness in larger cultural stories (Kogan & Gale, 1997). Using a similar metaphor, this therapy could be described as deconstruction in conversation, a process whereby the power and pervasiveness of the medical discourse is challenged and problematized. In this way, conversational space is created to allow for a multiplicity of diverse explanations to be dialogically produced within the clinical conversations.

Early in the therapy, Tom's identity is primarily constructed in terms of pathology and the medical discourse. He is represented as an object to be observed and closely scrutinized: an incoherent, irrational, mysterious, bizarre, and possibly dangerous child, whose actions can only be rendered meaningful through the interpretative gaze of professionals, all constructions which allude to cultural representations of autism (Avdi, 1998). The objectifying implications of the psychiatric discourse are expressed through the discursive obliteration of Tom's agency and his positioning as an object rather than an intentional subject. In addition, the power of the diagnostic discourse is expressed through its domination, as a single all-pervasive explanation for all of his actions.

Tom as an object of scrutiny, an incomprehensible Other

The following extract, which is from the beginning of the first session, is part of Anne's narration of Tom's life and the story of the parents' gradual realization that there are serious problems in his development. It is used to illustrate the dominance of the diagnostic discourse in the construction of the problem and of Tom's identity, early in the therapy. In brief, Anne's account of Tom's difficulties centres on the view that he is autistic, while the therapist seems to be oriented towards decentring this account. One of the most important issues regarding the construction of Tom's difficulties, which is under negotiation throughout the therapy, relates to the agency attributed to him, that is, the extent to which he is talked about as someone who can be understood as a person, with his own desires, intentions and aims, and with a meaningful and comprehensible inner world, which is expressed and made intelligible through his actions.

Extract 1 (Session 1)

Anne – he started making some movements, that is, he started to say 'ah' very intensely, '*aaahh*', he started to make these movements [*makes hand-flapping movements*], he started to hop and to clap his hands

Therapist – did these remind you of anything?

Anne – they didn't remind us of anything because we didn't know anything about such matters, but we definitely thought that something was not quite right

Therapist – did they remind you of a child younger than Tom? Because usually this is the sort of hand clapping that babies do . . . .

Anne – no it wasn't that sort of clapping, this is the sort of hand-clapping, not like the children to whom we say 'clap your hands', Tom does it when he is very pleased, that is, he sees a picture and he claps, he does this thing, moves his hands like this [*makes hand-flapping movements*], he goes round and round sometimes, around himself, it is not the sort of clapping that shows us that he is a child . . ., to me it was indication that something was wrong, it is not the clapping of a child. . . (. . .) we could see Tom did not say anything any more, he didn't even say 'hello', nothing, he did nothing, and these things he does started to occur with greater intensity, that is, he started saying '*ahh*' more intensely, the hand-clapping became more intense, he started seeing some pictures, not all pictures, and to hop

> Therapist – what pictures was it, usually?
> Anne – oh it makes no difference what the picture is, it could be just a line (. . .)
> Therapist – do they have colours, are they painted? What is his favourite picture?
> Anne – I cannot say that he has a specific picture, it is a thing of the moment, he may get hold of a magazine and he will look at it and choose from the whole magazine one picture and he will like it and he will start hopping around.

Anne enumerates a list of behaviours, which are used as evidence that there is a problem with Tom's development: non-verbal vocalizations, bizarre ritualistic movements, hand-flapping and hand-clapping movements, all of which are commonly associated with autism. She provides a vivid and apparently factual description of these symptoms, and her account is structured so as to suggest that what is being described is a true and accurate version of reality, something that is observable and objectively represented by an unbiased and disinterested narrator (Potter, 1996). The therapist's first question invites Anne to give her associations to and thus to attribute her personal meaning to Tom's behaviours. In this way the therapist problematizes the psychiatric discourse, by not treating the behaviours described as symptoms, and by implicitly challenging the view they have a single fixed meaning, which is readily shared and agreed upon between the speakers. Anne structures her next utterance so as to strengthen the position that Tom has a pathological identity. She claims that, at that time, the parents did not see Tom's behaviours for what they 'truly' were (i.e. symptoms of autism), as they were naïve non-experts. She uses the pronoun 'we', to include her husband, and thus increases the persuasive power of her account. However, despite the fact that they did not have the necessary knowledge for 'such matters', her argument goes, the parents could still discern a problem. Thus, Tom's difficulties are constructed as not only clearly observable and objective facts, but as obviously indicative, even to a non-expert, that something is wrong.

Next, the therapist articulates more forcefully an alternative explanation for Tom's 'out of the norm' behaviours: they can be seen to be the actions of a young baby. One implication of this developmental hypothesis is that it allows for the possibility of change. This is an example of the use of a reversal in order to decentre the dominant account, a common discursive strategy in narrative/constructionist therapies. A reversal represents a statement that subverts or reverses a dominant narrative, which in this case involves a shift to an alternative perspective (Tom acts as a younger child), that undermines the current framing of the problem (Tom is autistic/psychotic; Kogan & Gale, 1997). Anne, however, resists this lead and continues to construct, with increased intensity, a description of Tom as a child different to a normal child, and in doing this she draws from cultural representations of disability as Otherness (Shakespeare, 1994). She constructs Tom's hand-clapping (which she describes as 'this thing', an utterance which implies that it is something extraordinary, beyond words and common understanding), as a clear indication of a serious problem, and as qualitatively different to the clapping of a normal child. The fact that Anne does not actually use, but clearly

implies, the word 'normal' as well as her systematic vagueness, renders her account more dramatic and arguably more persuasive (Edwards & Potter, 1992). She continues by asserting that both the parents could see Tom's difficulties, and produces yet another list of 'suspect' behaviours, all of which are constructed as extreme, employing extreme case formulations (Pomerantz, 1986). The therapist makes a second attempt to shift to an alternative account, by introducing the idea that there may be a pattern, and consequently a meaning, in Tom's actions, which Anne explicitly denies. In this way Tom's actions are constructed as senseless, random, non-comprehensible, and Tom is represented as a child whose internal world is considered unreachable by rationality and common sense.

Viewed from the point of action orientation, that is, in terms of the interactional business that is achieved through the particular construction of accounts, Anne's talk could be seen to accomplish several functions. It has been argued that parents who attend services with difficulties with their child attempt to accomplish a delicate balance between convincing experts of the reality of the problem, whilst refuting any possible accusations of blame, and between appearing sufficiently interested and caring parents, but not too over-emotional, irrational, or over-protective (Avdi, 2002). As far as the therapist is concerned, her textual agenda seems to be that of decentring, which, in the above extract, is attempted through the establishment of a position of critical curiosity, and the promotion of multipositionality. Multipositionality relates to an epistemological position, shared by various postmodernist theories, which involves an explicit expectation that there are more than one version of events and points of view (Burck *et al.*, 1998). In this process, the therapist deploys a psychological/interpretative discourse, which is set in contrast to the medical discourse. Although these two discourses are not necessarily mutually exclusive, they prioritize statements in terms of their explanatory power in different arrangements. In line with the psychological/interpretative discourse, the therapist's accounts implicitly assert that nothing in psychic and interpersonal life is random and that behaviour always contains some meaning, even though it may not always be immediately apparent. This view usually carries the implication that mental health professionals have a special expertise in discerning and deciphering this 'hidden meaning'. In this extract, however, the therapist does not invoke her expert status explicitly, but rather works to establish multipositionality.

The introduction of an interactional frame: Negotiating agency as relatedness

Below, an extract is presented from the sixth session, where the parents discuss their current difficulties with Tom, after having reported significant improvement. It will be used to illustrate the following claims: (a) that there is a shift in the parents' talk towards greater flexibility and fluidity in their use of different discourses, (b) that there is a shift from a dispositional to an interactional understanding of Tom's behaviours, and (c) that there is a shift towards a representation of Tom in terms of agency, which here is primarily constructed in terms of being in touch and connectedness, that is, relationality.

Extract 2 (Session 6)

Anne – What worries me a lot now has to do with his behaviour, that is, the fact that he sometimes runs uncontrollably, he makes these movements, he moves his little hands like this

Th – tell me when do you remember him running uncontrollably, where was it?

Anne – it happens daily, daily, it could happen while we are playing, while we are still playing

John – if you leave him free for some time

Anne – without. . .

John – if you leave him free for some time he immediately becomes

Anne – his attention becomes distracted

John – yes, in a moment, say, or in seconds, that is, during. . .

Anne – play

John – yeah, yeah, immediately, Tom may do whatever he hasn't done all day, for example, he may run aimlessly somewhere, he may move his little hands like this towards his face, he may make some other movement, he may move his hand, I don't know, he may shout somehow in a strange way, without . . ., he may do other things, and what he says is not rational

Anne – however I have ascertained the fact that he *always* follows, er, always follows what we are saying, because I see that he watches me (. . .)

John – what I have noticed with Tom is that he may *appear* to you that he does not understand you and that he is not listening to you but

Anne – he is *always* present

John – yes

Therapist – like now, he is listening to us, isn't he?

Anne – yes

Therapist – [to Tom] are you listening to what we are saying?.

Anne starts by defining her concerns as relating to Tom's behaviours, which are represented as conveying no meaning and as being outside his control. In this way, agency is located 'inside' the symptoms, which are represented as the manifestations of an underlying illness/condition, and which are abstracted from Tom and the context of his life and relationships, yet projected within him. This has been shown to be one of the implications of talking about 'problems' in terms of the medical discourse (Harper, 1998). The therapist asks the parents to describe a specific instance of one of Tom's behaviours, employing an expansion question; that is, a question which attempts to produce a context or perspective shift and which functions to expand the language resources restraining current definitions or perceptions of an issue (Kogan & Gale, 1997). In this way, she invites a description that is contextualized, specific and interpersonal, rather than a generalized description, which privileges dispositional explanations. In response to this question, the parents jointly construct an account of Tom as prone to becoming distractible and absent-minded, and employ various rhetorical devices, such as a joint construction and extreme case formulations, to factualize their account (Pomerantz, 1986). However, there is a shift in relation to

Extract 1 regarding the way Tom's symptoms are talked about, as these are now discursively contextualized. In other words, Tom's behaviours are still represented as symptoms (and thus as 'products' of his condition) but these symptoms are now framed as interactionally triggered. This construction has the implication that a more dynamic understanding of the problem is introduced, whereby modification of the problematic behaviours becomes possible. Moreover, it contains elements of an alternative version, which is further developed in later sessions; that is, that Tom's behaviours are meaningful and functional.

What is interesting in this extract is how Anne continues with a strongly articulated counter-claim regarding the construction of Tom as absent-minded and out of touch, which draws from a discourse of intentionality (Burck *et al.*, 1998): although Tom is easily distracted and will start behaving oddly and irrationally if left alone, this does not mean that he is, in fact, lost in his own world. Anne makes a very strong case, using phrasing that implies absolute certainty and invoking the discourse of empiricism, that Tom is always fully aware of his surroundings. John builds on this alternative construction, by introducing the idea that Tom may appear (and may come to convince someone who may not know him better) to not listen or understand, although in reality he is perfectly able both to listen and to understand. Thus, an alternative perspective is introduced, whereby Tom is not seen to be at the mercy of his symptoms, but as a competent social agent. Here, the contrast between reality and appearance is used to suggest that behaviour may not be an accurate reflection of inner states, and that Tom, like other people, acts intentionally in order to achieve certain aims. In addition, a contrast is being formulated between Tom's actions, which are framed as primarily governed by his condition, and a more passive awareness, which is framed as evidence of his connectedness to his surroundings, and which implicitly functions to undermine the view that he is autistic. The therapist joins in this new construction and brings it 'alive' in the present-time interaction, by addressing Tom directly, rather than talking about him. This conversational manoeuvre has two important effects. On the one hand, it provides 'direct' evidence for the claim that Tom is listening closely to what is being said, right here and now in the clinical dialogue, a reality witnessed by all present. On the other hand, Tom is represented as a subject-in-relationships, someone who is not just passively aware of his surroundings but who can actively participate in the ongoing conversation.

Summarizing the above, this extract has two important effects, which are further elaborated in later sessions. Firstly, it points towards a construction of Tom as displaying some sort of intentional behaviour, in choosing to appear in a particular way. This makes attributions of blame possible, but it also introduces the possibility of change, as Tom may 'decide' to behave differently. In addition, it locates Tom's actions in the specific context of relationships with his parents, a construction which is less likely to be seen to reflect a dispositional pathological trait. In this way, both an agentic and an interactional discourse are employed to construct Tom's identity. This is in contrast to the suggestion that the tendency of psychotherapy to promote an agentic discourse results in the

marginalization of alternative, more relational discourses about the self (Guilfoyle, 2002). In this extract, the agentic discourse actually complements a relational/contextual discourse, as agency is defined in terms of attentiveness and openness to relationships. This may relate to the specifics of the diagnosis of autism, which is usually constructed in terms of disconnectedness and alienation from close relationships (Avdi, Griffin, & Brough, 2000). Furthermore, it is suggested that the promotion of an agentic discourse is particularly significant in situations where a psychiatric diagnosis exists, which typically has the effect of objectifying the person diagnosed.

Challenging the notion of Otherness

The following extract, which is from the eleventh session, is presented to illustrate the claim that a shift was observed in the way Tom is constructed in relation to Otherness, which has implications for the agency attributed to him. Constructionist critiques of psychiatric diagnosis have suggested that one of its disempowering and objectifying implications is that it positions the person diagnosed as Other, that is, as subject to different 'laws' and ways of being understood than 'normals'. This is an idea akin to liminality, that is, the culturally held assumption that people with a psychiatric diagnosis or a disability are fundamentally different to 'normals', and are positioned as hovering somewhere between subjectivity and objectivity, humanity and animality (Shakespeare, 1994).

Extract 3 (Session 11)

> Anne – I sometimes think about this and I tell John that in some ways Tom, let's say, functions like us, when we are tired and we don't want to talk etc., that's how Tom is, and John says 'how can it be possible for him to feel so tired that he doesn't want to talk, he is so young', 'yes, why not?' 'but he is little'
>
> Tom – is likkle. . .
>
> Anne – he is little, er, and at that point John may start to see that Tom might in fact feel just like a grown-up does
>
> (. . .)
>
> Therapist – do you withdraw as well, become absent-minded. . .
>
> John – no
>
> Therapist – in order to take some distance from the routine of everyday life?
>
> John – no, I don't become absent-minded, I simply get bored, I get bored.
>
> Anne – I become absent-minded, that is absent-minded in the sense that I let my mind go, and it drifts beyond reality, that is, I could think of the most unbelievable things the time that . . ., there are days when I do not want to speak at all, that is, a whole day may pass and I may not want to say even one word (. . .) the occupational therapist said yesterday, she described to me a report for Tom and I told her 'what you describe about Tom's development', about the autistic features she says that Tom has,

'you are describing myself to me', because she said that he would be cyclothymic, isolated, he will not make friends easily, he will not make the first step

John – reserved

Anne – he will be eccentric, a difficult character, stroppy, bad-tempered, etc., in a way she described *exactly* myself, that is, I am a person who doesn't make friends easily, I will never make the first step. . .

Therapist – and how did your self seem as a future for Tom?

Anne – I thought, well, I survived, he will survive too

Therapist – it was a relief . . .

Anne – yes, and knowing Tom's problem and knowing the good and the bad parts of my character I could tell Tom later, or, I don't know, I could somehow show him, that it is wrong to be isolated and not to make friends.

In the first part of the extract Anne presents an account in which Tom's lack of speech, which early in the therapy was represented as clear evidence of autism, is constructed in terms of normality. In the apparently typical conversation between John and herself, she presents a debate around whether Tom can be understood in the same terms as an adult. In this instance, a comparison is deployed between the categories of 'child' and 'adult', in order to propose an explanatory framework for the differences between Tom and themselves. This is in contrast to comparisons with other children and with abstract developmental norms, which constitute a powerful way of operationalizing a child's differentness and constructing an abnormal identity (Avdi *et al.*, 2000). Here, Tom participates in the unfolding conversation for the first time with speech. Moreover, it is noteworthy that Anne uses Tom's utterance to further her account, in a joint construction form, thus treating him as a conversational partner.

The second part of the extract follows a brief conversation regarding Tom's absentmindedness, where the view that it is a meaningful reaction to a restraining and repetitive routine is discussed. The therapist asks whether the parents react in similar ways, thus introducing the idea that Tom's absentmindedness carries some meaning and that this meaning can be deciphered in a similar way as for other people. John defines his reaction as different, but Anne says that she reacts just like Tom: she becomes absent-minded, that is, her mind drifts and 'it' thinks of bizarre thoughts. In this way, she constructs the boundaries between rationality and irrationality as relatively fluid and negotiable, transcending the binary opposition between normality and abnormality. Importantly, she represents herself as of the same 'essence' as Tom. She continues building this notion in relation to another of Tom's behaviours, which again was formerly used as a prime example of pathology: his lack of speech. This symptom is now reconstructed as a normal, understandable, and common reaction to being tired or bored. Moreover, she clearly distances herself from the view that Tom has autistic features, by attributing it to the occupational therapist and in this way rejects its claims to factuality. Then, Anne positions herself as 'exactly the same' as Tom and constructs

his behaviours – which were formerly represented as symptoms – as character traits similar to her own.

This construction, which again represents a shift in relation to the first and second extracts presented, has several important implications. Firstly, it allows for the possibility of change, as character traits are constructed as malleable versus symptoms, which are framed as intractable. Secondly, it presents a powerful challenge to the notion of Tom as Other, as it attributes comprehensibility, meaning and functionality to his actions. On the other hand, this discursive 'normalization' of Tom, and in particular his representation as 'exactly the same' as Anne may also function to deny his differentness, something that may also become restraining, if used in a singular way. Finally, this construction positions the parents as the most appropriate experts to understand and help Tom, by virtue of their similarities and their life experiences.

The analysis does not aim to suggest a position regarding the usefulness or appropriateness of a diagnostic label, but aims to highlight ways in which this is negotiated within a specific clinical interaction and attempts to link this with the process of therapy. The 'effects' that a diagnosis of autism has on a family's network of meanings and the ways it is used by parents in their interactions with professionals are complex and variable, and lie beyond the scope of this study (see Avdi, 1998).

Discussion and concluding remarks

The current analysis of a systemic therapy, with a family whose child has been diagnosed as autistic, suggests that an important aspect in clinical work with families with a member with a psychiatric diagnosis lies in decentring the dominant, pathology maintaining accounts, and allowing for a wider range of less problematic narratives to emerge. This claim is in line with the theoretical position of constructionist therapies regarding the creation and maintenance of problems and their dissolution (e.g. McNamee & Gergen, 1992). More specifically, as argued theoretically, and as suggested by the analysis, the dominance of a unitary, rigidly held, pathologizing account – which in this case concerns the child's identity as autistic – can be problematic. Moreover, positive change would, theoretically, be expected to be associated with the deconstruction of the diagnostic discourse, a claim which would also be in line with the current analysis (e.g. Dallos & Hamilton-Brown, 2000).

As already mentioned, several discourse analyses of psychotherapy talk have focused on the issue of flexibility in discourse use by various family members. The current analysis has traced shifts in the way the child's difficulties are talked about, from a dispositional to a relational understanding and from a non-agentic to agentic formulations regarding the child's behaviours, and has associated these with a decentring of the medical/ diagnostic discourse. One interesting aspect of this analysis is that it focuses on the construction of a pathological identity of a young child, who is not treated as a voice (both in a literal and a metaphorical sense) either in the family or, at times, the therapy. In addition, the analysis highlights the complex ways in which the

child's pathological identity is intertwined with the parents' own identity as good parents as well as their relationship with professionals. However, such an analysis does not aim to, an indeed cannot, provide answers regarding the many sensitive and contested issues that arise when working with families and children with special needs.

It is important to clarify that what is being argued here is not just that the descriptions of the problem which co-evolve in the clinical dialogue are somehow 'better', that is, more health-promoting than the unitary, pathologizing diagnostic discourse, although such a claim would be in line with a systemic view (e.g. Sluzki, 1992). It is suggested that what is helpful is the process itself of decentring the dominant diagnostic narrative and the subsequent widening of available explanatory frames. This process has been elsewhere described as 'story-breaking' and has been conceptualized as a challenge to a rigidly-held narrative in relation to the problem (Holmes, 1998). This is in line with contemporary approaches to psychotherapy, from various theoretical schools, which promote the view that the fluid and creative use of discourses and of diverse subject positions is associated with well-being. However, this assertion does not necessarily apply to all therapy situations. It is rather suggested that the importance it seems to have in part reflects the specific difficulties addressed in the particular psychotherapies studied. An alternative, opposite, emphasis may be found to be important in therapies where the clients' narratives are primarily characterized by disorganization and/or lack of coherence, as suggested in other discourse and narrative analytic studies of psychotherapy (e.g. Dimaggio & Semerari, 2001; Lysaker, Lancaster, & Lysaker, 2003; Stiles, 1997).

In recent years there has been a move towards linking process research with the study of therapy outcome (e.g. Marmar, 1990). Although the focus of this analysis is on the process of therapy, it could be argued that the 'outcome' of a systemic therapy relates to changes in the way that important issues are discussed, in line with contemporary systemic conceptualizations of the family as a linguistic/semantic system (e.g. Anderson & Goolishian, 1988). Clearly, more discourse analytic research is required before such a claim can be substantiated. Nonetheless, from a constructionist perspective on psychotherapy, discourse analysis can provide a useful interpretative tool in the study of therapy process, highlighting how problems, identities, and therapy are 'talked into being' in actual practice. It is also argued that the close examination and analysis of actual therapeutic sessions through a discursive lens can enhance therapist reflexivity, both with regards to theory and practice. This involves bringing into attention to the effects that the therapist's interventions have on the unfolding of talk, the assumptions that underlie the theories s/he uses, as well as the wider sociocultural context within which therapy operates and, sometimes, reproduces.

Finally, it is important to note that this reading, as all readings, has limitations that relate to the biases of the researcher and the analytic procedures employed. For example, the focus of this analysis, on the changes in the way the identified patient's identity is constructed through talk, risks obscuring the rhetorical aspects of therapy, such as the persuasive aspects of the therapist's talk, the biases in her theories, as well as

the power dynamics in the clinical interaction. More specifically, a limitation of this analysis lies in the fact that it does not focus in analysing critically the therapist's talk. The therapist's agenda in deconstructing the dominant diagnostic narrative through various discursive strategies, as outlined in the analysis, is seen to be in line with the aims of a systemic therapy; that is, shifting current conceptualizations of the problem from an individual dispositional understanding to a relational, contextualized, systemic understanding. In other words, her agenda is treated as undeniably 'therapeutic' and is not critically analysed. This position may function to conceal the effects the therapist has in shaping the unfolding talk, thus subjugating alternative understandings, and fails to highlight the multifaceted and complex ways that the therapist's institutional power and her presuppositions function to shape the talk in clinical conversations, as shown in other discourse analytic studies (e.g. Burman, 1995; Guilfoyle, 2002; Kogan, 1998; Kogan & Gale, 1997; Roy-Chowdhury, 2003; Stancombe & White, 1997). Other than the theoretical commitment to systemic practice, this bias in the analysis may also relate to the researcher's position as a member of the families' team.

In summary, in this paper it is suggested that discourse analysis is a useful approach for the detailed study of the ways in which meanings evolve within the clinical dialogue and of the institutional and ideological context of psychotherapy. Through the presentation of an analysis of a small number of extracts from a systemic therapy, it was suggested that discourse analysis can be used to shed light on the discursive work that takes place in constructing, deconstructing, and re-constructing crucial issues in the clinical dialogue. Such analyses may contribute to the current concern in psychotherapy research with developing methods of approaching, conceptualizing, and analysing the process of psychotherapy, which are in line with the contemporary emphasis on language, narrative and meaning-making, and which respect detail, complexity, and differentness, rather than privileging uniformity. Furthermore, it is argued that a discourse analytic approach can enhance clinicians' critical reflexivity through detailed readings of the clinical dialogues, through problematizing the therapist's participation in the clinical dialogue and through making explicit the sociocultural context of the therapy and the prejudices that inform his/her talk.

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