

Introduction

This book is about psychotherapy. But it does not share the perspective normally adopted in the specialist research literature in clinical psychology. Instead, it sheds light on therapy from a perspective that plays a minor role in that literature. Rather than looking at therapist interventions in sessions, I look at the key role of the clients' experiences and activities in bringing about the outcomes of their therapy. What is more, since therapy is meant to work on the clients' troubles in their everyday lives outside sessions, I study the interplay between sessions and the clients' ongoing everyday lives between and after sessions in other places. I did so by following what goes on in the therapy sessions as well as in other social contexts of clients' ordinary lives outside sessions throughout a small number of family therapy cases. Indeed, in order to reach a more complete understanding of the workings of therapy, we need materials that cover what goes on in sessions as well as in other contexts of the clients' lives.

But the book is even more about persons in social practice. I use therapy as a case in point to study clients as persons changing in their ongoing everyday lives, among other things, in response to the deliberate change efforts of their therapy. However, as soon as we stop believing that personal change in relation to therapy occurs only within sessions, we need a theory that takes appropriate account of the fact that persons change and learn in the course of moving through a set of diverse social contexts: their sessions, home, school, workplace, and so forth. It should allow us to grasp how personal changes and learning are accomplished in a complex personal, social practice. Such a conception is also necessary for understanding the workings of other specialist, professional practices on their clientele. What we see in relation to specialist practices, in fact, reflects a much more general and basic feature of what it means and takes to be a person in social structures of practice. Persons live their lives participating in diverse social contexts with diverse purposes, scopes, and coparticipants. They link these parts of their lives in particular ways and pursue their personal concerns across them. We need a theory of persons built on recognizing these basic facts. Such an approach to personhood is of general value for understanding persons living their lives in social practice. In this book I present my work on developing such a conception of personhood. The most crucial theoretical background in psychology for my study and the conception I develop is critical psychology (see, first of all, Holzkamp 1983;

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Tolman 1994; Tolman and Maiers. 1991), which is a variant of the activity theory of the Russian sociohistorical school developed by Leont'ev (1978; 1979) and others.

I approach therapy as a social practice and persons as participants in social practice. Researching and theorizing about both in new ways based on a theory of social practice has led me to crucial new insights. This new approach has also contributed to the study of social practice by expanding our understanding of persons in social practice and by studying a field of social practice, psychotherapy, that has barely been studied from the point of view of a theory of social practice and may seem particularly intractable to such an approach. Additionally, I combine a situated approach with a new emphasis on the contextual and structural arrangements of social practice, which adds to our conception of social practice.

My approach to the study of therapy and persons should also be relevant for researchers in other fields of social practice. In fact, its development was deeply inspired by comparisons with studies of other fields of practice. Uncovering similarities and differences between fields provoked, stimulated, and consolidated my viewpoint. Of primary importance is the inspiration offered by Jean Lave's research on learning and education, which encouraged me to launch a similar approach to the study of persons learning in social practice (Dreier 1999a; 1999c; 2001; 2003). Likewise, my project inspired other related projects on various topics, such as child development (Højholt 1999; 2001), genetic counseling of lives at risk (Huniche 2002; 2003), rehabilitation following brain injuries (Borg 2002) and the use of facilities at home after the injury (Forchhammer 2006), educational trajectories of young immigrants (Mørck 2006), and training interventions in the Nigerian prison system (Jefferson 2004).

The book falls into four parts. Chapters 1–3 make up the first part. In chapter 1 I establish the need for my approach and this study in relation to the existing research on psychotherapy. In chapter 2 I introduce my theoretical framework on social practice and persons in social practice, and in chapter 3 I introduce the design and conduct of my study. The next two parts of the book focus on a detailed analysis of a case from my study: a family of four undergoing a prolonged outpatient family therapy. Chapters 4–7 make up the second part of the book. Chapters 4 and 5 address how clients link their participation in sessions and in other social contexts of their ordinary lives. Building on this understanding, chapters 6 and 7 analyze changes of clients and their problems. Chapters 8–11 make up the third part of the book. It begins with a theoretical chapter. Chapter 8 introduces the concepts of personal conduct of everyday life and the personal life trajectory. These concepts provide a broader understanding of the persons in the case. I use these concepts to analyze the two daughters in chapter 9 and the two parents in chapter 10. In chapter 11 I round off the third part by analyzing the conduct of their everyday family life and the unfolding of their family trajectory. Chapter 12 makes up the fourth part of the book. Here I characterize the theoretical and empirical outcomes of my case study and the possible uses of such outcomes.

1 Re-Searching Psychotherapy as a Social Practice

In this chapter I ground the need for my approach and study of the social practice of clients in relation to representatives of characteristic positions in the existing research on psychotherapy.

1.1. The Received View in Research on Psychotherapy

The following framework about the practice of therapy dominates research on psychotherapy: In therapy sessions a professional expert acts on a client with a particular diagnosis (or problem) by means of a particular technique and thereby causes a particular outcome in his client. Many studies include other subordinate factors too. One such factor is about the client and the relationship between therapist and client (Hougaard 2004). But it is seen as the obligation of the therapist, and as a crucial part of his technique and expertise, to account for, call forth, and control those other factors. Studies of them should ultimately add to the prevailing understanding of a publicly accountable practice of therapy as caused by what the therapist does in sessions. Some basic canons of this framework are crucial for grounding my critical arguments in this book.

Technical Rationality

The therapist's expertise consists in a general knowledge from which a set of techniques are derived as professional know-how. The therapist is to effect his client's treatment by applying this knowledge and set of techniques on her. So the concrete conduct of therapy is ultimately derived from a general knowledge. The vast literature about the conduct of therapy addresses therapists with the following message: as an expert you should know and consider all this; you are the sole knower and the ultimately responsible agent and cause of this practice; in your practice you should follow and apply this body of knowledge; if you do so properly, you will cause in your client the general effect that we found. Schön (1983) calls this point of view the technical rationality of modern professionalism. It presupposes a firmly bounded and specialized general knowledge, well-defined general problems and means, and agreement about predefined and fixed ends. Professional practice then simply consists in the application of this general expertise. However, "uncertainty, complexity, instability, uniqueness and value conflict" abound in professional practice (17).

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Technical rationality, therefore, falls short of offering an appropriate basis for professional practice.

According to technical rationality, a theory offers practitioners direct answers to their questions about what to do in concrete cases and situations. In fact, the argument that a theory offers a general means for practitioners to find out what to do by observing and analyzing in concrete cases and situations is often met with disappointment and frustration. Therapeutic practice is also believed to follow from what the expert does. Yet, the conduct and outcome of therapy is not up to him alone. Other persons are involved in creating them. Good therapists acknowledge and consider this – whether things go as they intended or not. The conduct and outcome of therapy are a distributed effect of what everyone who is somehow involved does and thinks (Dreier 1998b, 627). So it is a mistake to assume that a therapist merely needs a good theory and techniques to succeed and, when he does not succeed, to blame the theory and techniques he adopted for the failure. No theory and techniques can fulfill such demands. If the relation between theory and practice is understood this way, problems of self-evaluation arise for practitioners and between practitioners and researchers (Dreier 1983; 1993b). We need a different conception of this relation. I argue that we need a theory of the social practice of therapy in structures of social practice with multiple participating parties.

Medical Model

The dominating framework is an application of the medical model on psychotherapy (e.g., Bohart and Tallman 1999, 5–14). Its abstract concepts of diagnosis, technique, outcome, session, therapist, and client stem from this model as does the claim that standard procedures of treatment applied to standard diseases and problems produce standard outcomes (Jensen 1987).

Institutional Epistemology

The diagnosis and treatment of diseases and problems are understood from the position and perspective of medical institutions, that is, the institutionalized diagnosis and treatment of mental illness. Practice in these institutions gradually leads to an understanding marked by the special institutional arrangement it emerged from. More specifically, the outlook is affected by the position, perspective, and stakes of therapeutic experts in relation to patients in these institutions. This includes how therapists cope with diagnosing and treating their patients in the special situations of these institutions and the behaviors and mental states they may observe their patients exhibiting here (Prior 1993). Following Foucault, Gordon (1980) calls it an institutional epistemology (see also Rose 1996b, 60–62).

Guild Innovationism

The framework advocates that the decisive condition for improving the lives of patients is to subject them to professional treatment. Accordingly,

professionals should be given means to develop their practice. Lewis et al. call this belief guild innovationism (1991, 6) arguing that

When the mentally ill were treated in large state institutions, both psychiatric and sociological theories viewed patients as if they were a homogenous group. . . . Regardless of disease or label, patients were seen as victims. If their situation was to be made better, the system of care had to be changed. Because they were victims, the key to improvement lay in changing what others did to them. (3)

Decontextualization

The prevalent assumptions about the relation between theory/technique and practice imply a particular definition of the practice of therapy and delineation of what to study in the wider social practice of therapy. The practice of therapy is seen as occurring exclusively inside an isolated situation: the session. Although sessions actually are particular parts of clients' lives elsewhere and of therapists' institutional work practices, the conduct of sessions is assumed to be independent thereof and the mode of working of therapy to consist in an immediate link between cause and effect in sessions. This is where the powers of expertise are exerted and consumed and the expert may witness how the client is reacting. Therapy researchers look for the factors that bring about the treatment effect in the session, though they do not yet agree on which factors and details of these sessions really are the effective mechanisms of therapy. Even so, they are convinced that they must be found exclusively in the session. This belief also serves the professional interest in documenting that the therapist is the cause of his client's cure and fits with the methodological credo of a science of variables (Holzkamp 1983), which must be isolated and analyzed as immediate links between cause and effect. All the same, abstracting the session from its links with its participants' practices in other places amounts to a decontextualized understanding of the very same therapy (Dreier 1993a; 1993b) that promotes a naturalized notion of diseases, diagnosis, treatment, and outcome (Smith 1990). The actual contextuality of the social practice of therapy then goes unnoticed. Neither the institutional practice of therapists nor the lives of clients in other places surface in the account of how treatment works. We are left with an institutional epistemology that denies the institutional nature of its understanding and expertise and dissolves the particular contextuality of the session into a seemingly unobtrusive and insignificant container – a privileged nowhere of mental change.

1.2. Process Studies in Sessions

The understanding of the workings of therapy in isolated sessions is carried over from outcome studies to process studies about the unfolding of therapy across time to bring about treatment outcomes. Effective processes in sessions are here construed as immediate causal links across a sequence of isolated sessions. Though much else goes on between sessions, the process of therapy

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is re-construed as a sequence of sessions linked with each other and nothing else in a causal chain across time. The arrangement of a sequence of sessions, of course, links these really separate events with each other, but these links are not immediate and exclusive. Process studies re-construe the course of therapy as a continuous process across discontinuous occasions. Interpretations by therapists and researchers are the means by which this continuity is construed. Thus, in their interpretation, narrative accounts of therapy (e.g., Mattingly 1998; McLeod 1997; Polkinghorne 1988; Rennie 1994b) construe a continuity and wholeness of process and meaning across time (Dreier 2000). We find a similar framing of studies and interpretations in other fields of professional, institutional practice. The social practice of education is an obvious example. Here a student's learning of a school subject is construed as the effect of teaching in isolated lessons. At the end of a school year, the student's level in the subject is assessed as the sum effect of immediate causal links between lessons in that subject, which are scattered across the timetables of days and weeks among many other school subjects and much else in the life of the student.

Process studies of therapy increasingly argue for an eclectic or integrative understanding of therapy. The argument is directed against deriving practice from one theory but not against the idea of deriving practice from theory with the accruing problems mentioned previously, as long as several theories are included and the practitioner himself decides the mix. The argument also goes against the formation of theories as competing schools of therapy and private, professional societies occupying particular specialties, populations, or domains of therapeutic practice (Dreier 1989; 1993b; Markard and Holzkamp 1989).

In line with this trend, nonspecific or common factors are claimed to lie behind therapeutic change regardless of theoretical orientation (e.g., Hougaard 2004; Lambert 1992). These factors are (a) the extratherapeutic factors; (b) the therapy relationship; (c) the therapeutic techniques used; and (d) expectancy, hope, and placebo. Attention has moved away from deriving therapy from a theory and its associated technology, and numerous process studies (e.g., Siegfried 1995) seek new ways of understanding the process and dynamics of therapy.

Greenberg's (1999) programmatic proposal for the study of psychotherapy represents a strong empiricist trend in this research. He claims that the field has been too closely tied to psychological theories and hopes that it is now "mature enough to develop a 'basic science' of psychotherapy. . . . Science proceeds by observation, measurement, explanation, and prediction. Limited attention, however, has been paid to the initial steps. In fact, intensive, rigorous observation of how change takes place probably has been the most sorely neglected" (1467). He advocates

the intensive analysis of in-therapy performance. One of the major difficulties inherent in the current use of clinical trials or comparative outcome studies is the assumption of direct and linear cause-effect relations between independent

variable (treatment) and dependent variables (outcomes) without taking into account the complex performances that occur between treatment delivery and outcome effects. Rather than treating therapy as a black box, looking only at input and output variables, we need to study and track the complex performance patterns and interaction sequences that constitute psychotherapy. (1467–1468)

Evidently, such process studies also address what happens in isolated therapy sessions, where the effective ingredients of therapy are sought in its particular detailed features. Greenberg has a later phase of research in mind. Once solid, general empirical findings are established, it will be time to construct other theories. But he seems to see them as related to practice in a way similar to what I argue is problematic.

A distinction is often made between two strategies of process studies (Hougaard 2004; 1996). The first strategy uses direct methods of observation considered to be more objective, while the second uses indirect methods of asking participants about the sessions afterwards via questionnaires or interviews. While the first rests on a third-person perspective on clients and therapists, the latter builds to some degree on their first-person perspectives and thus introduces a plurality of perspectives to the same process. Greenberg proposes using both strategies, first closely observing actual behavior in sessions and afterward asking “participants about their subjective experience at particular moments to further illuminate what is occurring in these moments using tape-assisted Interpersonal Process Recall” (1999, 1468).

1.3. Professional Centeredness and Desubjectification of Clients and Therapists

All the same, “the majority of writing and research has been and continues to be on the therapeutic technique, intra-session therapist activity, and the development of treatment models – factors that make a much smaller (15%) contribution to overall psychotherapy outcome” (Miller, Duncan, and Hubble 1997, 37). So we may add a sixth characteristic of the received framework. It is professional centered, that is, it understands therapy from the position and perspective of the professional practitioner – or his ally, the researcher – and highlights what he should know and do in the session (Dreier 1993a; 1993b).

Upon closer inspection, we here see a seventh characteristic. Much writing on therapy is quite desubjectified (Dreier 1993a; 1993b). This is a paradox since psychotherapy deals with eminently subjective matters. Nonetheless, most writing is couched in a third-person perspective, as seen from the position and perspective of someone other than the person whom the statement is about. The ensuing confusion of perspectives reduces our chances of a fuller understanding of the participating persons. Thus, most writing about the therapist sees him as a vehicle for the treatment of his client, thinking, feeling, and doing what he does for his client’s sake (Osterkamp 2003), as if his reasons for acting the way he does really could be derived from somebody else. This

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leads to a skewed and reduced understanding of the therapist as a subject in his own right conducting his work in particular structures of social practice. These and other aspects of therapist subjectivity are relegated from the session into another special setting: the supervision. So, while the majority of the literature in a sense centers on the therapist, it offers a poor understanding of him as an acting and experiencing person. Conversely, most writing about clients is seen from the position and perspective of the therapist or an associated researcher. Clients are described as they are interpreted in a professional centered, third-person perspective and not from their own position and perspective. Much has been written about clients, but they are understood too abstractly from the positioned perspective of professionals and researchers. Even in studies giving voice to clients, they are primarily asked about their perspectives on the workings of their therapy, that is, the sessions, the techniques used, and the therapist, again making them talk about someone else (the therapist) rather than about themselves as acting and experiencing persons in a broad sense. So, we cannot trust the understanding of clients such a framework offers. Miller, Duncan, and Hubble give a vivid account of the professional centeredness and third-person understanding reminding us that when clients enter therapy, they are perceived to be less than competent, to have an understanding of themselves that cannot be trusted, to be bearers of pathology rather than full persons, to be resistant, and to be targets of intervention. Therapists, on the other hand, are seen as masters of coping with this and of curing their clients. "There are hundreds of books about great therapists but few, if any, books about great clients" (1997, 24–25). At professional workshops and conferences, clients are turned into live demonstrations of therapist mastery.

We can now add an eighth characteristic of the framework. A professional privilege or monopoly of interpretation dominates the field and inhibits the articulation of the perspective of clients in a social practice supposed to exist for their sake (Dreier 1991). Because of the therapists' involvement in this practice, they focus on particular features of client subjectivity but gloss over and conceal others by their interpretations. The therapists' desires to do well as therapists for their clients affect their understanding of clients. As time passes, a professional culture of interpretation about their clientele unfolds as part of the existing institutional epistemology (Dreier et al. 1988). It comprises a core blindness (Lave and Wenger 1991) because therapists take for granted, ignore, or reinterpret particular features of their practice.

1.4. Client Perspectives in Sessions

With no comprehensive research on client perspectives, therapists have to create a culture of therapeutic interpretation of clients in their practice. This professional-centered culture of interpretation easily sidetracks the study of client perspectives. Scholars proposing studies of client perspectives

assign a different status to client perspectives than to those of therapists and researchers. Therapist perspectives are claimed to represent “expert clinicians’ cognitive maps,” whereas client perspectives merely represent “clients’ internal experience” (Greenberg 1999, 1468). Or, researchers and clinicians possess scientific knowledge about diseases, whereas patients possess experiences of illness characterized by the cultural, social, and personal meaning of symptoms and suffering for the sick persons, members of their family, and wider social network (Kleinman 1988). Still, studies of client and therapist perspectives on their shared session show that they experience even this shared context differently. Therapists and clients tell different stories about the same therapy (Yalom and Elkin 1974), and retrospective accounts by clients offer perspectives significantly different from practitioners (Sands 2000).

The growing trend to study client perspectives indicates a change in research, as seen in *From the Mental Patient to the Person* (Barham and Hayward 1991); that is, investigators are going beyond studying homogenized categories of diseases and treatment in the medical model. Yet, almost all studies of client perspectives focus on their experiences of sessions, techniques and therapists, so they are studies about being a client, as in *On Being a Client* (Howe 1993), rather than about persons living troubled lives. After all, attending therapy is only a part of clients’ lives. In their book *User-friendly Family Therapy*, Reimers and Treacher (1995) thus report studies of client perspectives on the therapeutic arrangements, the therapists, and their interventions in the interest of using these perspectives to evaluate traditions of therapy and to develop professional technologies. By zooming in on clients’ perspectives on the interventions and their therapists, Reimers and Treacher inadvertently turn away from studying clients as persons in the full sense of the term and toward studying the professional therapeutic practice and therapists from the third-person perspective of their clients. In doing so, they partly desubjectify the interviewed clients and give in to the pull of professional centeredness. Such studies tell us little about what clients learn and do apart from experiencing and consuming these professional services.

A few studies of clients’ relations to their ongoing therapy report findings their therapists would normally not come to know about. This indicates a need for separate studies of client perspectives. In deference to their therapists, clients do not report all they are thinking to their therapists (Rennie 1994a). Clients appraise their therapists’ plans and strategies, contrast them with their own preferences, and sometimes feel critical of limitations in their therapy and therapists. Nor do clients always find the therapists’ responses most helpful, and they sometimes “creatively reinterpret the response so they could use it to stay on their own track” (Tallman and Bohart 1999, 48–49). Such findings question the widely held assumption that good therapy presupposes a good understanding between the therapist and the client, which is taken to mean that they basically share the same understanding. Above all, the therapist’s expertise is seen in his ability to understand his client and to do so even better

than the client herself does. The attributed lack of self-understanding is seen as an indication of the client's need for treatment, and client progress is seen as the client coming to share the same understanding as her therapist. If clients and therapists hold on to different understandings, that is believed to counteract the workings of therapy and taken as a sign that something is problematic and not going well. Conflicts between them may, of course, become prominent, but therapeutic traditions contain concepts to deal with such conflicts by treating them as expressions of resistance, and so forth; in other words, they are regarded in ways that support therapists' control over their practice.

One study of the relation between client and therapist perspectives on their shared sessions played a crucial role for my project. In a small number of cases Eliasson and Nygren (1983) confronted therapists and clients separately after sessions with video recordings of the past session and interviewed them about their experiences thereof. In all cases studied, therapist and client experiences were strikingly diverse. Asked to identify important episodes in the session, therapists and clients pointed to different episodes. The clients had understandings of their therapists' goals, plans, and intentions that differed from their therapists. The same was true for the therapists' understandings of their clients' experiences and reactions. Still, therapists rarely find out that their clients' perspectives may differ so much from their own. They are highly surprised upon seeing glimpses of contrasting perspectives and normally justify the differences by referring to their clients' lack of background in the therapeutic traditions. Besides demonstrating the need to capture the perspectives of clients as well as therapists, Eliasson and Nygren's study raises other nagging questions: If therapy is experienced so differently by clients, how then are we to account for its phenomena, dynamics, and effects? It seems doubtful to make do with accounting for therapy from the perspective of the therapist – or the researcher. Do therapists and researchers instead need a better understanding of the diverse perspectives of their clients if they are to produce valid accounts of therapy? And do we not need a different understanding of the practice of therapy that allows us to comprehend the existence of different client and therapist perspectives?

1.5. Clients as Agents, Consumers, and Users

Most studies of clients only look at how they experience their therapy in sessions. They capture client experiences as a reaction to what somebody else, the therapist, does. In that sense they see clients as reactive and passive. A few studies also consider clients as agents of their therapy and as instrumental in bringing it about. For instance, Bohart and Tallman view the client as “a creative, active being, capable of generating his or her own solutions to personal problems if given the proper learning climate . . . no matter how emotionally troubled they may be. They can be used as the therapist's creative collaborator” (1999, xi–xii). There are different notions of client agency in these studies. Rennie (1990; 1994a; 1994b) sees clients as exhibiting reflexivity, while Bohart