GOING BEYOND EVIDENCE BASED AND COMMON FACTORS APPROACHES: A SOCIAL CONSTRUCTIONIST MODEL OF THERAPEUTIC FACTORS

by

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I declare that **GOING BEYOND EVIDENCE BASED AND COMMON FACTORS APPROACHES: A SOCIAL CONSTRUCTIONIST MODEL OF THERAPEUTIC FACTORS** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I have not previously submitted this work, or part of it, for examination at UNISA for another qualification or at any other higher education institution.

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Mr FN van Zyl Date

ABSTRACT

The inception of psychology as a practicing profession in 1938 brought with it a continuing scientific struggle geared towards cementing its place as a value-adding health service in the form of psychotherapy. Concepts such as Empirically Supported Treatments (ESTs), Evidence Based Treatments (EBTs) and Evidence Based Practice in Psychology (EBPP) arose out of research attempts to scientifically prove the efficacy of psychological treatment versus psychiatric medications or versus no treatment. This focus on evidence in psychotherapy partly stems from, but also influences public policy in the form of practice and training mandates as well as government and insurance funding policies for psychotherapy. At present ESTs, EBTs and EBPP are the source of polarisation among psychologists who argue for either sides of this controversy, raising questions on a practical/policy level as well as an epistemological level. This thesis differentiates between ESTs, EBTs and EBPP as well as the Common Factors approach and continues to critically investigate the advantages, practical/policy implications and epistemological critiques against these approaches**.** Some of the identified shortfalls resulting from unwarranted epistemological (empirical) assumptions are addressed by proposing a social constructionist model of therapeutic factors based on social constructionist- and eco-systemic theories. The proposed model allows therapists to employ EBT's in conjunction with various other (excluded) approaches that are available in their arsenal of treatments. Clinical case studies are used to illustrate the model's practical operation in therapeutic contexts.

Keywords: Evidence Based Treatments (EBTs); Empirically Supported Treatments (ESTs); Common Factors; Evidence Based Practice in Psychology (EBPP); Empiricism; Critical Psychology; Social Constructionism; Deconstructionism; Psychotherapy; Therapeutic Models

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CHAPTER 1

> *Given [the] history of squabbling among historians, what is to be done? How can one fashion a critical perspective out of the competing claims of traditional, revisionist, and counter-revisionist historians? If we accept that psychologists are not inherently malevolent, how can we explain the frequent use of psychology in support of unjust social relations? If we accept that earlier psychologists' methods were no more ridiculous than those of physicians or other social scientists, do we lose our ability to criticize the often mindless empiricism of our field today? If revisionist historians misunderstood the politics of the early IQ debate, how can we hope for a political understanding of psychology in the rest of this century?* (Prilleltensky & Fox, 2009, p. 30).

Traditionally psychology, and specifically the fields of psychotherapy and family therapy, has been characterised by feverish academic debate surrounding the basis and mechanisms of behavioural/psychological change (Norcross & Newman, 1992; Prochaska & Norcross, 2010; Sexton, Weeks & Robbins, 2003).

From their roots in ancient philosophy (Plato, Aristotle, Descarte, Kant, etc.) to their inceptions in the field of science (Wundt, Freud, Pavlov, etc), and even in modern times, different paradigms (worldviews) and models of psychotherapy compete for recognition as ‘authority’ on human behaviour and/or 'treatment of choice' in the pursuit of behavioural change.

This competition is best illustrated in the current drive for evidence informed treatments wherein the treatment, which is 'shown empirically' to yield the most change for [enter

behavioural problem], is ultimately recommended as treatment of choice (Fourie, 2012; Lindegger, 2007). Such recommendations then serve the current philosophy of 'best practice' that underlie medicine and medicalised psychology (Sexton et al., 2003).

The concept of *best practice* is poised to become difficult to resist, especially since it is likely to have a significant impact on medical aid funding (Lindegger, 2007) as well as on professional councils that prescribe accountable practice guidelines to clinicians (Sexton et al., 2003). Sexton et al (2003) go so far as to say that in numerous areas, including justice and managed healthcare settings, the concept of best practice has become *the* criterion that informs decisions to fund treatment programmes.

This reality not only poses important challenges for psychotherapy practitioners, but also for theorists and thinkers who develop models of psychotherapy practice. Of the numerous challenges, the two that stand out are first, at a practical level: How will psychotherapists successfully treat clients from a Best Practice approach when they (psychotherapists) have been trained in different models of psychotherapy?

Related to this question, yet at a more theoretical- philosophical level, the second challenge asks the question: How (if possible) can differing worldviews on psychotherapy be accommodated in a best practice approach, when such an approach itself is anchored in a positivistic worldview?

In attempts to reconcile differing models of psychotherapy, many theorists have turned their attention to the identification of common factors that are presumed to be responsible for behavioural change during psychotherapy (Fourie, 2012). Sexton et al. (2003) claim that the common factors movement has led to the development of "...more specific, systematic, and well-articulated clinical models...[and] the emergence of "family intervention *science*"..." (own emphasis added, p. xxiv).

The latter quote, taken from the preface of a prominent family therapy textbook, illustrates clearly how positivist notions such as *best practice, evidence based practice* and *common factors* can infiltrate and draw professional discourse into the realm of positivism, by proposing empiricism and essentialism as the chosen avenues to solve the practical and philosophical challenges that face psychotherapists.

1.1 AIMS AND RATIONALE

While acknowledging the contributions of evidence based and common factors approaches, it is the opinion of the author that a social constructionist model of therapeutic factors is needed in order to address some of the serious epistemological flaws (which underlie existing models of therapeutic factors) that limit its accessibility and relevance to some of the post-modern approaches to psychotherapy.

The aim of this dissertation was three-fold: First, to outline the epistemological foundations and assumptions of current evidence based and common factors approaches together with arguments from an eco-systemic and social constructionist viewpoint to illustrate the philosophical biases that underlie these models.

The second aim was to argue for the consideration of eco-systemic and social constructionist inputs to address the shortcomings in current models of evidence based practice and common factors. A social constructionist model of therapeutic factors is proposed and discussed in terms of its benefits to the current field of therapeutic outcome research.

Finally, the author aimed to operationalise and illustrate the proposed model's practical utility and relevance by making use of various case illustrations to highlight different aspects of the model. An in-depth case formulation is also provided to assist with the latter aim.

It is acknowledged from the outset that the proposed model is birthed from an exploratory attempt to make well-established, yet theoretically abstract social constructionist

concepts more accessible for practical application in therapeutic settings. As a result, the author trusts that the proposed model will stimulate further research into its utility and relevance as well as its application in various professional contexts.

1.2 TRUSTWORTHINESS AND CREDIBILITY OF THE STUDY

As a means of promoting the trustworthiness and credibility of the present research, emphasis is placed on open and transparent self-reflection and fair representation of different views. In addition, Ballinger's (2006) guidelines for the evaluation of the quality of research findings are offered to encourage the reader to continuously engage in the evaluative practice of assertions made in this study.

The first of Ballinger's (2006) considerations involves the coherence of a study. This includes an evaluation of the extent to which there is a fit between the various aspects of a study, including the aim of a study, the methods used to pursue this aim, the worldview that influences a researcher's decisions regarding his or her study and the extent to which a researcher acknowledges his or her role in producing the findings.

The second consideration concerns the extent to which the reader can see evidence of systematic and responsible research conduct. Such evidence might be reflected in the degree to which a researcher has given thought to his or her impact on participants, given the way he or she presented himself or herself to them, as well as through the provision of fitting extracts that have been accurately transcribed, described and contextualised to clearly illustrate the researcher's interpretations (Ballinger, 2006).

The third consideration deals with the degree to which a researcher's interpretations are convincing and relevant. Apart from being compelling or interesting, Ballinger (2006) also recognises that research should contribute to the knowledge or understanding of the domain under enquiry.

Finally, the reader is also encouraged to consider whether a researcher has shown sufficient reflexivity, meaning that he or she has shown sensitivity to the role he or she plays in the research process and outcomes, and that this role is appropriately accounted for given his or her epistemological orientation (Ballinger, 2006).

1.3 ETHICAL CONSIDERATIONS

As the content of this dissertation is primarily of a theoretical nature, many of the ethical dilemmas that are relevant to qualitative research studies are absent. Furthermore, the clinical case studies that serve to illustrate various aspects of the social constructionist model of therapeutic factors are based on existing clinical records that were produced by the author in the course of therapeutic work. All case clients' therapeutic processes were concluded by the time of their inclusion in the study.

Given that case illustrations are based on existing clinical records, ethical standards do not require that informed consent be obtained on the condition that clients' anonymity be protected. With respect to the issue of informed consent, Eysenbach and Till (2001) report that:

> *…non-intrusive research such as retrospective use of existing medical records may be conducted ethically without the express consent of the individual subjects if the material is anonymised at the earliest possible stage, if there is no inconvenience or hazard to the subjects, and if the institutional review board has reviewed and agreed the research protocol* (p. 1104).

Nevertheless, all efforts were made to obtain informed consent from case study clients for inclusion in this study. Also, all names and personal particulars that might lead to the identification of case study clients were changed as a means to protect their anonymity.

Departing from the research aims and methodological issues raised in this introductory chapter, the rest of this text focuses on providing a comprehensive and critical overview of the evidence based approaches, common factors theories as well as social constructionism as they pertain to the field of therapeutic factors and outcome research (Chapters 2 and 3). A social constructionist model of therapeutic factors is outlined in Chapter 4. Chapters 5 and 6 are dedicated to practical illustrations of the proposed model with the help of clinical case studies. The thesis concludes with Chapter 7, a critical discussion of strengths and limitations of the model as well as suggestions for further research.

CHAPTER 2

INSTITUTIONALISED PSYCHOLOGY: EST's, EBPP AND COMMON FACTORS

The field of psychology has a long history, as described in the previous chapter. As will be demonstrated, the field of psychology, and perhaps more so psychotherapy, has through time embodied several different 'roles' in historical discourse. These roles include psychotherapy: 'As philosophical enquiry'; 'as mystical practice'; 'as devil's advocate'; 'as saviour of the damned'; 'as right arm of the oppressor'; 'as voice of the oppressed'; 'as peacemaker/fence-sitter'; 'as an institution'; 'as personified being'. To say that these roles are part of the history of psychotherapy may be only half true, since they all, in current times, form part of the identity of psychotherapy, and in a broader sense psychology.

The contemporary field of psychology addresses diverse views on what psychotherapy should entail, what it should do and how it should be done. These views, which have developed over the course of psychology's history, currently finds expression in different philosophical schools of psychotherapy (Meyer & Moore, 2003). Some of these schools (e.g. cognitive behavioural psychology) are based on positivistic epistemologies and advocate objectivity, standardised practice (i.e. manualised treatments) and reductionist practices that attempt to isolate the working factors of psychotherapy (Bryceland & Stam, 2005; Meyer & Moore, 2003). Other schools (e.g. feminist and critical psychology) are based on postmodern epistemologies that emphasise power relations, oppression of minority views and emancipative practices (Bryceland & Stam, 2005; Fox, Prilleltensky & Austin, 2009).

Still other schools (e.g. narrative and second order systems psychology) are based on postmodern epistemologies that focus on the social construction of realities through language, discourse and negotiation, including what is deemed normal, deviant, unlawful, ethical,

healthy, etcetera (Bryceland & Stam, 2005). Finally, some schools of psychology (e.g. African psychology) are based on cultural epistemologies and practices that developed independently from the western conceptualisation of psychology. These approaches stress the importance of cultural and religious contexts that may explain deviant behaviours, and how cultural rituals are prescribed in order to restore a harmonious balance of the individual with his or her social surroundings (Meyer & Moore, 2003; Viljoen, 2003a).

What is important to note is that these different schools of psychology have evolved out of the varied needs of diverse groups of people to find appropriate explanations for the problems they encounter. Therefore different schools of psychology were formed in a variety of contexts where each was deemed to be appropriate in explaining the psychological problems encountered in that specific context (Viljoen, 2003b).

For example, the behavioural school developed in a social context where mental health care was based almost exclusively on inferences relating to sub-conscious psychological processes that were at best hard to prove, and at worst attributed its failures to such sub-conscious psychological processes in the individual (Sternberg, 2001). A patient who failed to recover during the course of psycho-analysis was said to be resisting change, and hence this failure was attributed to the patient's unconscious personality, rather than being a failure of the approach itself. Hence, more psycho-analysis would be prescribed to deal with the patient's unconscious resistance.

Critics of psycho-analysis were of the opinion that as a scientific approach to mental health, it was "infallible" since its assumptions and attributions made it difficult and even impossible to falsify (Meyer & Viljoen, 2003). Because, the psycho-analyst is always right and the patient always 'wrong', the need for more objective 'scientific' approaches became strong, so that responsibility for failure was not placed exclusively on the patients' unconscious

processes. In this way behavioural psychology served the social need in western contexts to avoid a single treatment method (i.e. psycho-analysis) being enforced on all patients when there was no way to test its appropriateness and/or effectiveness (Sternberg, 2001).

Similarly, the school of feminist and other critical approaches in psychology developed in social contexts where the modernist views of progress sought to bring all people into compliance with the socially accepted definitions of normality. The scientific fervour at that time to correct the deviant was based on the successes of positivistic science to bring order to many questions and problems in the world. With this order came the experience of power to control nature and the belief that eventually, given enough objective enquiry, scientists would control and bring to order any unwanted (un)natural occurrences, including many 'mental disorders' of the time such as homo-sexuality and other forms of social deviance (Becker, 2008; Rubington & Weinberg, 2008).

The critical psychology movement became important in a time when the status quo was intolerant of alternative lifestyles and it used science and psychology to label such lifestyles as unnatural and deviant. Critical approaches questioned the very notion of normality by suggesting that it never had pre-determined parameters, but that these parameters of normality were socially defined and laden with subjective and political agendas. By definition then, critical approaches questioned the 'objectivity' of positivistic scientists and criticised them for masking their subjectivity with scientific jargon (Fox et al., 2009; Teo, 2009).

The differing roles that psychology (and specifically psychotherapy) played over time stressed the dangers of utilising psychological knowledge out of context. Also the differing roles allow us to appreciate the important impact that psychology can have in shaping society when its practitioners assume specific roles in appropriate contexts. Some would argue that it is due to this constant reflexivity on context, through which psychology and its practitioners

gain the knowledge and power, that affects change (Cecchin, 1992; Hoffman, 1992). Thus, reflection, introspection and awareness of context are major aspects addressed in the training of psychologists (Hess, 2011).

It is evident that most psychology training programmes are designed to educate prospective psychologists about differing worldviews so that they can understand and work with people who function on the fringes of societal norms (Hess, 2011). However, as with many institutions, institutionalised psychology seems to be heading in the direction of becoming ever more prescriptive to its members, controlling how they should think and what practices they should avoid. Instead of encouraging divergent understandings and methods of enquiry, institutionalised psychology runs the risk of marginalising those who do not conform to its norm of empirically based practice.

The latter claim finds support in the various voices that express their opinions and grievances in the debate on, and some would say enforcement of, Evidence Based Practice (EBPP) and Empirically Supported Treatments (EST's) (e.g. Beutler, 1998; Bryceland & Stam, 2005; Chambless, 2002; Duncan & Reese, 2013; Fourie, 2012; Lampropoulos, 2000; La Roche & Christopher, 2009; Levant, 2004; McFall, 1996; McFall, 2000; Mcloughlin, 2001; Serpell, Stobie, Fairburn & Van Schaik, 2013; Wolf, Dulmus & Maguin, 2012; Young, 2014).

2.1 EST'S & EBPP: DANGLING CARROTS, LEADING THE BLIND?

Contemporary psychology discourse (as seen in scientific journals) is laden with questions of superiority, validation, defence and exclusion of psychotherapy practices. This discourse finds concrete expression in various institutional bodies that have come to be accepted as the authorities on psychology and psychotherapy. Examples of these include the likes of the American Psychological Association (APA) and its various right hands: the British

Psychological Association (BPA), the Health Professions Council of South Africa (HPCSA) board for psychology and all the other mandated governors of psychology and psychotherapy practice.

These bodies establish guidelines and sanction the practices that psychologists may or may not perform. These policies may affect the funding that other organisations (including medical aids) allow for psychological services (Bryceland & Stam, 2005; Cautin, 2011; Duncan & Reese, 2013). For instance, the APA Presidential Taskforce on Evidence Based Practice (2006) states the following regarding their view of effective psychological practice that informs their policy for funding of psychological services:

> *EBPP promotes effective psychological practice and enhances public health by applying* ***empirically supported*** *principles of psychological assessment, case formulation, therapeutic relationship, and intervention…Therefore, psychologists whose training is* ***grounded in empirical methods****, have an important role to play in the continuing development of evidence-based practice and its focus on improving patient care* (Own emphasis added, p.271).

Given the history of psychology and psychotherapy and the power these entities afford their users, misusers and abusers (see Cautin, 2011) it is no surprise that bodies such as the APA and HPCSA attempt to control exploitation and abuse of power by psychologists. These governing bodies go a long way in providing guidelines to its members (i.e. psychologists and those in training) for appropriately and responsibly practicing their profession in order to protect the public. What these bodies also took upon themselves, which is clear from the above

quote, is to promote and eventually mandate 'appropriate' epistemological and ontological worldviews for its members (i.e. psychotherapists and those in training).

Clearly the message promoted by the APA's stance on EBPP is that research and practice, based on *empirical* evidence, and that psychologists grounded in a *positivistic* worldview have important roles to play. Therefore, what is not explicitly stated in the APA's stance on EBPP is that research *not* based on *empirical methods* and psychologists who are *not* grounded in *positivistic worldviews* do not have important roles to play in the continuing development of EBPP and improving public health.

In 1995, before the advent of EBPP, an even more stringent movement advocated for the exclusive use and funding of empirically supported treatments (EST's) in psychotherapy practice (Duncan & Reese, 2013). The treatments included on these lists need to show that they are sufficiently empirical by adhering to specific criteria that are assumed to indicate their superiority over treatments that are excluded from these lists. Again, as one can deduce from its name, the EST movement is solidly based in a positivistic worldview in that it assumes empirical evidence is superior to other forms of enquiry. Also, it needs to be stated that the EST movement was again a product that was spearheaded by the APA, Division 12 (Society for Clinical Psychology) under the guise of a Task Force on Promotion and Dissemination of Psychological Procedures, 1995 (Duncan & Reese, 2013).

It is interesting to note that the EST and later the EBPP movements in psychology occurred in reaction to a similar movement in psychiatry that produced guidelines for psychiatric treatment of specific disorders (Duncan & Reese, 2013). Given their history of competitive rivalry for recognition and turf in the mental health field (Cautin, 2011), it is no secret that psychology is at risk of being left out in the cold somewhat with more and more

evidence flooding in to suggest biological bases for traditionally psychologically defined disorders (see Noggle & Dean, 2013).

Examples of the latter are numerous, including schizophrenia and other psychotic disorders, bipolar and major depressive disorders and even stress related disorders and anxiety disorders that can be effectively managed with psychiatric treatment (Sadock, Kaplan & Sadock, 2007). The co-occurrence of the EST movement shortly after a similar movement in psychiatry then is yet another clue pointing to the desire of governing bodies of psychology to establish 'their' profession as an empirical one, perhaps even embodying aspirations for psychology to be just like its bigger, more famous and respected cousin, psychiatry.

Apart from their practical and policy implications, it is clear from the preceding discussion that the EST and EBPP debates mask more fundamental philosophical issues related to the current state of psychology practice. It is argued here that psychology has evolved over time to play different roles that allowed it to liberate our minds from religious oppression and to broaden our understanding of human behaviour. Psychotherapy became a treatment choice when mentally ill patients were banished from communities or damned by the church as being possessed by the devil (Cautin, 2011).

Over time, psychology also became an institution, just like the church, with members similar to the church's congregation who are ordered by its governing bodies to treat the public according to its mandated guidelines and procedures as compiled in its holy bible, also known as the APA guidelines. Finally, as with the church, the APA and similar governing bodies stepped into the trap of assuming an exclusionary worldview, that is empiricism and promoting empirical evidence as the only gospel that can save the masses. Where it previously acted as a liberating science, psychology now in its institutionalised form may run the risk of becoming a dictating institution itself.

In order to understand the critiques of the EST and EBPP movement, it is necessary to first understand what these movements advocate, why they advocate them and why they have become such a force with which to be reckoned. The next section will provide definitions of EST and EBPP and outline their principles.

2.2 EST's AND EBPP: A LOOK BACK AT THE FUTURE

As it was alluded to before, the EST and EBPP movements in psychology are based firmly in a positivistic epistemology and as their names suggest, the proponents of these movements regard empiricism as the golden standard of scientific enquiry. Given their recent prominence (since 1995) in psychological discourse (e.g. Duncan & Reese, 2013; Fourie, 2012; Levant, 2004; McFall, 1996; McFall, 2000; Norcross, Beutler & Levant, 2006; Sparks, Duncan & Miller, 2008) it is tempting to think of the EST and EBPP movements as modern ones advocating for cutting edge treatment methods to increase the standard of care in mental health care. By examining them closer, one can see that these movements are tired old trends of yester years that have simply been dusted off, repackaged and sold as something new and promising.

2.2.1 EST's: The Beginning of a Controversy

With its brief in hand, the Task Force on Promotion and Dissemination of Psychological Procedures (1995), set out in 1995 to do what has never been done before. Its goals were clear and noble, and when achieved would cement psychology firmly in the scientific realm, eradicating any questions of its scientific inferiority and ensure that its scientist-practitioners' desires for professional validation and recognition are met. The Task Force was finally going to show that psychology is equal to medicine and has its answer to pharmacology in the form of lists of empirically supported treatments.

With these carefully crafted lists, it was believed that any form of clinician subjectivity would be eliminated. Just like psychiatrists, psychologists would merely have to diagnose the patient's condition, consult the lists to see what psychotherapy is indicated for that condition and then follow the step-by-step manualised approach to fix the patient's problem. The 1995 Task Force heralded the age of empirically validated treatments (EVT's) and what would later become empirically based treatments (EBT's) or empirically supported treatments (EST's) (Duncan & Reese, 2013).

The initial report of the Task Force included promising results that led to ambitious and controversial recommendations. The result of its toil was a short report that included an initial list of 25 empirically validated treatments (including well-established and probably efficacious treatments). The majority of the well-established treatments were cognitive behavioural treatments with a few interpersonal therapy treatments as well as brief psychodynamic therapies as a grouping (Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

The recommendations that followed from this and subsequent reports on EST's included, among others, that training in EST's become a priority, that EST's become a high priority issue in the accreditation of doctoral programmes, that funding for treatments be determined by their empirical status, and even that it should be deemed unethical and punishable for clinicians to use approaches that were not on the EST lists for specific disorders (Duncan & Reese, 2013; Levant, 2004; McLoughlin, 2001; Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

Following the initial report of the 1995 Task Force, controversy erupted among psychologists who were on opposing sides of the EST camps. The Task Force and the EST movement were criticised for being biased in their criteria of what constituted evidence of

efficacy and it was suggested that the criteria favoured approaches such as Cognitive Behavioural Therapy (CBT) and Interpersonal Therapies that were more focussed on outcomes and lends itself to manualisation (Bryceland & Stam, 2005; Duncan & Reese, 2013; Stuart & Lilienfeld, 2007). Other critics held that manualised treatments do not allow for a full appreciation of clients' realities (Report of the CPA Task Force on Evidence-Based Practice of Psychological Treatments, 2012).

Furthermore, it was suggested that the EST movement was overly strict in its definition of what constitutes science (Levant, 2004) and that findings based on RCT's as used in outcome research have limited use in clinical practice due to a lack of external validity (Report of the CPA Task Force on Evidence-Based Practice of Psychological Treatments, 2012). In fact, Woody, Weisz and McLean (2005) report on some university directors' opinions of EST's, saying that the "…lists of ESTs reflect a political or theoretical bias more than they reflect treatments that work" (p. 11).

Proponents of EVT's, EBT's and EST's made strong statements that served to fuel resistance in this movement. For instance, Richard McFall, a former president of the Society for a Science of Clinical Psychology (Section III of Division 12 of the APA), declares the following in his manifesto for a science of clinical psychology: "…I believe that we must make a greater effort to differentiate between scientific and pseudoscientific clinical psychology and to hasten the day when the former replaces the latter" (McFall, 1996, p. 75).

Duncan and Reese (2013) point to attitudes of superiority held by EST proponents based on presumed evidentiary support as reflected in statements such as the following: "not administering EBTs [or ESTs] is unethical…and perhaps even "prosecutable"" (Chambless & Crits-Cristoph and Carey quoted in Duncan & Reese, 2013, p. 495). Furthermore, in the United States of America, government funding policy for mental health services have gradually

adhered to EST claims of superiority by restricting funds to community programmes based on EST's (Duncan & Reese, 2013).

Despite the strong governmental and institutional support the EST movement managed to garner, a 10 year follow up survey conducted in 2005 indicated that training in EST's at university level and in internships in America declined from 1995 (Woody et al., 2005). These authors cite philosophical opposition (especially the view that EST's represent a scientific bias) as one of the stumbling blocks responsible for the decline in training in EST's at university level. However, they conclude their article with the following words affirming their assumption of the supremacy of empirical science: "If the results of this survey are any indication, graduate training in clinical psychology has a long way to go before it reflects the scientific basis of the discipline" (p. 11). Among other concerns, it is the EST movement's assumption of superiority, despite clear practical and philosophical weaknesses, that lead their critics to protest loudly in objection to its worldview of exclusivity.

Duncan and Reese (2013) observe that the EST movement's call for accountability via empirical research support may in itself have questionable empirical justification. They point to weaknesses in the research that support the notion of model-specific factors, including the implausibility of conducting true randomised clinical trials (RCT's) in psychotherapy outcome research; as well as the mounting empirical evidence (including dismantling techniques) that negate technique-specific effects and refute claims of superiority by any one approach. Duncan and Reese (2013) conclude their critique on EST's by remarking that "…the evidence points in the same direction. There are no significant unique ingredients to therapy approaches, offering no justification for mandating EBTs [or EST's]" (pp. 497-498).

2.2.2 EBPP: Different Name, Same Controversy?

The controversy surrounding EST's resulted in the birth of what is today known as Evidence Based Practice in Psychology (EBPP). Some argue that EBPP is just a euphemised term for what essentially is still EST's, whereas others outline important differences between the two movements (Duncan & Reese, 2013).

The shift from EST's to EBPP occurred in 2005 when the APA established a Presidential Task Force on Evidence-Based Practice in Psychology. According to the APA, evidence based practice was different from EST in that the former integrated "…the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273).

From the definition provided above, it is clear that the APA Presidential Task Force attempted to repair the divide caused by the EST movement and its insistence on empirical evidence. Instead, the Presidential Task Force emphasises the need for best available research, which it states may include effectiveness studies, process research, common factors research, single-subject research, as well as case studies and qualitative research (Duncan & Reese, 2013). The EBPP approach then has a broader definition of what qualifies as evidence, while the EST approach stresses the importance of empirical evidence in the form of randomised clinical trials (RCT's) (Duncan & Reese, 2013; Fourie, 2012).

Apart from their definition of evidence, the EBPP movement also emphasises the importance of clinical expertise as exercised when a clinician bases a treatment decision on previous experience and/or subjective judgment. This is in contrast to the EST approach that seeks to eliminate all forms of subjectivity (including clinical judgment) by means of standardisation. Finally, the EBPP movement also factors in aspects of the client's

characteristics and preferences that should be considered when making treatment decisions (Duncan & Reese, 2013).

The Presidential Task Force describes the differences between EST's and EBPP in the following manner:

> *EBPP is the more comprehensive concept. ESTs start with a treatment and ask whether it works for a certain disorder or problem under specified circumstances. EBPP starts with the patient and asks what research evidence (including relevant results from RCTs) will assist the psychologist in achieving the best outcome. In addition, ESTs are specific psychological treatments that have been shown to be efficacious in controlled clinical trials, whereas EBPP encompasses a broader range of clinical activities (e.g., psychological assessment, case formulation, therapy relationships). As such, EBPP articulates a decision-making process for integrating multiple streams of research evidence—including but not limited to RCTs—into the intervention process* (APA Presidential Task Force on Evidence-Based Practice, 2006, p 273).

Although the Presidential Task Force went a long way to address some of the controversial issues that stem from the EST movement and made the evidence-based approaches to treatment more inclusive of approaches that do not lend themselves to manualisation and RCT's, there are still critics of both these movements (Bryceland & Stam, 2005; Duncan & Reese, 2013; Norcross et al., 2006; Stuart & Lilienfeld, 2007).

Despite its commendable effort to expand the narrow view of evidence proposed by the EST movement, the EBPP movement continues to exacerbate the notion that some therapies

are ‘more equal’ than others (Duncan & Reese, 2013). For instance, research regarding the implications of evidence based practice in social work (Drisko & Grady, 2012) has found wide discrepancies in the application of evidence based practice guidelines on micro- versus macro-levels. While in practice EBPP, as it is defined, encourages the incorporation of clinical expertise and patient values into the treatment decision process, on health-care policy levels, health funders tend to forego these aspects of the EBPP process by merely providing lists of approved treatments for which they are willing to pay. As such, clinical expertise and client values become lost in translation from the EBPP definition to its application at a policy level. It is also pointed out that the compilation of these lists lacks transparency and that criteria for inclusion to these lists are not explicitly stated (Drisko & Grady, 2012).

While the concept of EBPP may be admirable on paper, it seems its pragmatic effect on health care policy is marginally different from that of the EST movement. Through EBPP’s insistence that practitioners consult lists of evidence-based treatments in order to make decisions on which treatment would get the best results, it reinforces the assumption that the magic ingredient lay in the specific approach rather than in the therapeutic alliance that is built.

Such lists provide opportunities for health-care funders to restrict treatment options based on questionable claims that some treatments are better than others. This problem emanates from the fact that EST and EBPP movements both advocate the same assumptions that therapeutic models themselves contain ‘active ingredients’ much like a psychiatric drug contains an active substance that is essential to its potency (Duncan & Reese, 2013; Fourie, 2012; Sparks et al., 2008).

What was initially a metaphor for psychotherapeutic conversation, the medical model has seemingly seduced some researchers to believe that the therapeutic potency of their

conversations with clients can be isolated, condensed into context-free manuals and/or therapies and marketed and sold as cures for specific life problems.

Perhaps the future of psychology (as envisioned by evidence-based proponents) holds the potential for a dispensary of psychotherapy treatments outside our offices. Here clients can stand in line to collect their potentially harmful psychologist-prescribed psychotherapy or if they just feel a bit under the weather they can opt for the self-therapy dispensary where they find a Schedule one or two therapy, no questions asked.

After all the empirical approach is clear in its promise: *'True facts on the underlying order of the world will be unveiled as our empirical observations eventually converge over time'* (Sternberg, 2001). One may therefore ask whether the medical model really fits psychotherapy so seamlessly or are we making the same mistake as the nude emperor flaunting his new robe to the public?

2.3 EMPIRICALLY BASED ASSUMPTIONS: A MEDICAL MODEL FOR PSYCHOTHERAPY?

Informed by a positivist epistemology and relying on empiricism as a guiding approach to scientific enquiry, evidence based approaches operate from the fundamental positivist assumption that reality exists with a pre-existing order that is independent of human observation and interpretation. Moreover, the assumption is made that humans can access this underlying order of things via observation through their senses, given that they adhere to certain scientific conditions (Wendt & Slife, 2007). These include that their observations be systematic, controlled, neutral and unbiased in order to qualify as being empirical (Sternberg, 2001).

Wendt and Slife (2007) make the following remark with regards to psychology's relationship with empiricism: "…empiricism is not viewed as a particular epistemology or philosophy at all but as a transparent window to the way things are" (p. 613). Despite Von Foerster (1984) raising serious epistemological objections to the very concept of objective observers, it has become generally accepted that psychology as a science should rely primarily on empirical evidence, meaning that many other forms of evidence are relegated to the realm of non-science or pseudo-science (Wendt & Slife, 2007). For example, Sternberg (2001) states:

> *The difference between the psychological approach to the study of the human mind and the approach of the humanities is psychology's emphasis on scientific theory and methodology as its means for conceptualizing and* ***empirically*** *testing ideas* (Own emphasis added, p.4).

Moreover, those who make use of other forms of evidence (i.e. non-empirical evidence) are frequently shunned and criticised for being "non-scientific" and even unethical (see Duncan & Reese, 2013; McFall, 1996). This occurs despite numerous illustrations of the credibility and trustworthiness of non-empirical methods for scientific enquiry (Ballinger, 2006). Furthermore, it is questionable whether empirical methods of enquiry (for example the use of RCT's) are always appropriate when studying human behaviour (Duncan & Reese, 2013; Fourie, 2012).

Nonetheless, it seems as though the history of psychology has established a scientific hierarchy with empirical methods at the pinnacle of the mountain of evidence. If its inherent superiority is in fact based on assumptions, then why is it that some researchers would bend over backwards to prove that their findings are empirically derived rather than through some other scientific method that is perhaps more appropriate?

Through adopting a scientific stance (or more correctly an empirical stance), fields of study such as medicine have been able to systematically map the human body into its basic components (i.e. cells), and its supra-systems (i.e. bodily structures, organs and organ-systems). Understanding how these components interact with each other to affect normal bodily functioning also allowed medical scientists to understand abnormal bodily functioning and how to correct it. This in turn led to the development of medical technologies, such as surgery and medications that are applied following a thorough assessment of the underlying bodily problem.

This model of treatment (i.e. the medical model), based on an empirical method and positivist assumptions, has served the field of medicine well. Due to its success, the medical model has been adopted (with sometimes questionable appropriateness) in most, if not all, spheres of human functioning, including emotional, cognitive and social spheres (Bryceland & Stam, 2005; Fourie, 2012; Sternberg, 2001). After all, it is argued that our emotional, cognitive and social behaviours are products of a biological organ, the brain, and thus can be affected by abnormalities in the structure or functioning of the brain. Although the latter argument is quite sound, adoption of the medical model in psychology has far reaching implications as will be discussed briefly below.

2.3.1 Underlying Personality

Beginning as early as 384 BC, philosopher of science, Aristotle, proposed that reality exists in the objects we observe, and hence all objects of our study have an underlying and pre-existing order (Sternberg, 2001). For example, Aristotle proposed that an object of study (e.g. a chair) exists as a meaningful object in external reality and that its existence is independent of the interpretations and observations of its observer. In other words, Aristotle argued that the

meaning of the concept of a chair is inherently contained in the object of the chair and that we can discover this meaning by directly and objectively observing the chair.

Following Aristotle's empirical view of objects of study, meant for psychology that personality too should have a pre-determined, underlying structure that exists 'out there', perhaps in the brain's structure, and that its secrets are waiting to be uncovered by wily scientists with crafty methods (read empirical methods) meant to cast light on the true nature of every personality.

Of course, Aristotle's thesis had an antithesis that came from his teacher, Plato, in 428 BC. For Plato, the meaning and nature of objects did not reside in external reality, "but in the abstract forms that these objects represent" (Sternberg, 2001, p. 7). Plato's ideas, that reality is informed by the observer's perceptions, are embodied in contemporary theories of constructivism and social constructionism, which bring into question the idea of an underlying personality (Andersen 1992; Fourie, 1994; Frugerri, 1992; Van Zyl, 2009). This alternative view holds that we cannot study any external object without investigating our subjective interpretations that inform the meanings we attach to that object. Also see Hoffman (1992) for an insightful account of a social constructionist critique on the concept of personality structure.

2.3.2 Underlying Disorders

From the assumption that things exist 'out there' and have a pre-established natural order, positivists argue that anomalies in this pre-existing natural order are what lie at the root of many of society's problems (Teo, 2009). Thus, if an underlying order of things exist, disruptions in this natural order would result in problems or *underlying disorder* of things.

Translated into the realm of psychology, this idea of underlying disorders, has found expression in areas such as abnormal psychology and the Diagnostic and Statistical Manual of

Mental Disorders (DSM). In short, the positivist assumption is that human problems (including behavioural, emotional and interpersonal problems) are the result of a deviation from the natural order of things (Hoffman, 1992). Hoffman (1992) illustrates how positivistic notions of normality (i.e. an underlying natural order) have led to the distinction between normal and abnormal developmental pathways based on a subjective norm that leaves little room for alternative developmental pathways that fall outside the norm.

In this way then, positivist assumptions of normality flowed into the idea that deviations from the natural order of things are indications of disorder since they are a 'nuisance' to the norm or are at odds with the goals and expectations of the norm. Thus it is argued that deviations from the norm should be rectified in order to prevent psychological disorders and maladjustment as defined from the perspective of the norm (Hoffman, 1992, Van Zyl, 2009). This line of argument is reminiscent of the medical model tasked with the responsibility to remove obstructions from normal bodily functions.

Examples of the positivist normality bias are abundant, but probably best illustrated in the initial classification of homosexuality as an abnormal developmental pathway and thus a psychological disorder (included in the DSM III) that needed to be treated and rectified. Only in later editions of the DSM, and through societal pressure led by LGBT activists, was it recognised that homosexuality represents an alternative developmental pathway and not necessarily an abnormal developmental pathway (Van Zyl, 2009).

2.3.3 Diagnostic Labelling

Given the assumption that human problems result from a deviation of the natural order of things (i.e. a disorder of things), an extension of the positivist worldview on 'psychological

disorders' led to the necessity for diagnostic categories of specific disorders that have been proven to exist 'out there' (Van Zyl, 2009).

The act of *diagnosis* entails the identification of signs and symptoms that together suggest the presence of an underlying psychological or physical disorder (Barlow & Durand, 2005). A diagnostic label is then applied to the person who is said to suffer from [enter diagnostic label]. Any behaviour of the labelled person is subsequently interpreted in light of their diagnostic label and in many cases the diagnostic label is offered as an explanation for any subsequent behaviour. (See Van Zyl, 2009, for a detailed account of the process of reification of diagnostic labels).

The pitfall is that the diagnostic label is presumed to indicate an underlying and objectively existing disorder, and therefore if we know your diagnosis then we know how you are deviant from the natural order of things. The diagnostic label of a person then suggests what is wrong with this person and informs how they *should* be treated according to positivist standards.

Labelling theory suggests, however, that diagnostic labelling is an interactive process that is necessarily informed by the subjective interpretations made by the diagnostician of the 'disordered' and 'deviant' behaviours of the labelled individual. Furthermore, when diagnostic labels are applied to human behaviour they can serve to induce the behaviour they describe by altering others' expectations of and behaviours towards the labelled individual (Van Zyl, 2009). Thus, whereas diagnostic categorisation may work well for physical disorders, it may have negative consequences for individuals when applied to their presumed psychological disorders.

2.3.4 Psychotherapy as Treatment with Underlying Curative Ingredients

Since it is assumed in the positivist worldview that psychiatric diagnoses point to an underlying disorder of the normal order of things (i.e. normal personality or behaviour), the onus rests on scientists and psychology practitioners to devise methods to remedy this deviant state of affairs, as represented by specific disorders (Duncan & Reese, 2013; Fourie, 2012; Hunsberger, 2007).

In medical terms one might say that the body's natural hormone levels have become disrupted and thus medication is introduced into the body to restore the natural hormone levels. Comparatively, since the positivist worldview assumes that each psychological problem is a distinct disruption of an underlying natural order that exists in the mind or brain, it follows that a specific intervention (aimed at removing the disruption) should be used to restore the natural state of affairs of the mind.

Because positivists see things as existing 'out there', it follows that interventions also exist 'out there' and thus must have underlying and pre-existing ingredients that can act upon the underlying and pre-existing disorders of behaviour and in so doing restore the underlying and pre-existing order of personalities (Fourie 2012). It is argued therefore that, if a specific intervention is effective in providing relief for a given psychological problem, then according to the positivist worldview, there must be something inherent in the intervention itself that should be replicated in all instances of that specific disorder. It is this argument that lays the foundation of the current drive for EST's and EBPP.

Critics of positivist notions of abnormal behaviour and psychotherapy are of the opinion that their proponents seek to reduce complex human interactional phenomena to basic and simplistic elements that approximate a medical reductionist model of human behaviour (Fourie, 2012; Hunsberger, 2007). This medical model thus discounts the interactive process of the

individuals (i.e. clients and therapists) who are involved in the therapeutic endeavour. Instead the medical model focus is fixated on the effect of the treatment on the specific underlying disorder. Specific critiques of EST's and EBPP are discussed in a later section (See section 2.6).

2.3.5 What Counts as Evidence?

Seeing that all scientific enquiry is based on, and informed by, basic assumptions about reality and the extent to which researchers have access to that reality, it is problematic to favour one scientific approach above another. It is fair to say, however, that certain worldviews support certain approaches to scientific enquiry above others. As has been pointed out, the positivist worldview favours the empirical method as the gold standard of scientific enquiry since this method best serves positivist goals and rationales. In the realm of positivism then, methods of data collection such as introspection, hermeneutic analysis or even discourse analysis may be frowned upon as being unscientific (or more accurately unempirical).

However, alternative worldviews that inform scientific enquiry have developed and will continue to develop in what Thomas Kuhn describes as *paradigm shifts* (Kuhn, 1962). Examples of such developments include Roy Bhaskar's *Transcendental Realism* and *Critical Naturalism* (1998a; 1998b) as well as critical realism (Archer et al., 1998). The latter authors argue that scientific enquiry is only possible in so far as the objects of investigation have internal generative mechanisms that are activated during experimental procedures. Critical realists therefore argue that while reality exists independently from the observer, the observer's purpose is to identify and activate those generative mechanisms that govern events in the world out there, thus bringing into question the neutrality of the scientific observer.

Post-modernism, as an example of a paradigm shift, led to the adoption of alternative epistemological positions relative to scientific enquiry, including constructivist and social constructionist epistemologies (Van Zyl, 2009). As alternative epistemologies, these systems of understanding the world are also based on assumptions about reality and the extent to which researchers have access to reality. These assumptions then, in turn, inform their approaches to scientific enquiry as well as how they define and approach problems of a psychological nature (Van Zyl, 2009).

It seems, however, that the illusion of a unitary worldview of science and psychology persists through the institutionalisation of positivistic values and empirical methods as prescribed through regulating bodies of psychology (Wendt & Slife, 2007). Cries of disgust at the mere mention of using non-empirical methods reminds of reactions to the worst acts of blasphemy. These cries of disgust are then also an indication of the privileged position that the positivistic inner circle is granted. If science were religion then 'clearly', the positivistic priests seem to reassure themselves: '*only positivists can be called scientists and clearly any methods that are not positivistic (i.e. empirical) cannot be scientific'. 'And after* all', they declare: '*we are the ones chosen, privileged by Science itself to spread its gospel, and let it be known that whoever deviates from our ways are false prophets in service of a pseudo-science, false and foul.*

Having discussed evidence based approaches to psychotherapy with an outline of their underlying paradigmatic assumptions that promote the questionable use of a medical model of psychotherapy, the focus will now shift to a competing approach to psychotherapy outcome research. One that seeks not to divide ranks, but to unify differing models and even divergent worldviews by focussing on their commonalities.

2.4 COMMON FACTORS IN PSYCHOTHERAPY

Seemingly, both the EST and EBPP approaches are afflicted by the same ailment that pervades every aspect of their supporters' reasoning related to psychological treatments. That is, an absolute secure attachment to a medical model of psychotherapy leading evidence based proponents to assume that some therapies are inherently better than others for treating specific human problems as 'disorders of the psyche'. In opposition to this viewpoint, a different approach was developed to explain the effectiveness of psychotherapy and its various treatment models.

This different approach links to the *dodo bird verdict* that states that most models of psychotherapy are not only more effective than no treatment, but that they are all more or less equally effective as treatments for a variety of psychological disorders (Duncan & Reese, 2013; Fourie, 2012; Norcross & Newman, 1992; Sparks et al., 2008). Given its belief in the relative equality in effectiveness of different psychotherapy models, this different approach to psychotherapy effectiveness research seeks to investigate the commonalities between different models of psychotherapy (Fourie, 2012; Norcross & Newman, 1992; Sparks et al., 2008) and hence has been termed the *common factors* movement.

Norcross and Newman (1992) describe the common factors movement as an approach intent on discovering the 'core ingredients' that divergent models of psychotherapy have in common and ultimately devise more effective treatments using these common elements. Duncan and Reese (2013) describe the common factors of psychotherapy as "interdependent, fluid, dynamic, and dependent on who the players are and what their interactions are like" (p.498).

In contrast to the evidence based movements, the common factors approach to outcome research is critical of the comparison of therapeutic models in terms of model-specific

components and techniques. From as early as the 1930's critics of comparative outcome research (the basis of EST's and EBPP) have made statements on the low likelihood that technique-specific factors contribute significantly to the behaviour changes observed in psychotherapy (Duncan & Reese, 2013; Fourie, 2012; Norcross & Newman, 1992; Sparks et al., 2008).

According to Duncan and Reese (2013), the common factors movement can contribute "a big picture view of what really works" in psychotherapy (p.498). Similarly, Norcross and Newman (1992) point out that the field of psychotherapy is heading more and more towards the acknowledgment of the need for integration of various ideological understandings of psychotherapy with an appreciation of what is common to all models of psychotherapy. This call for integration has a long history that slowly gathered momentum over time.

Sparks et al., (2008) credit psychiatrist, Saul Rozensweig, as having made the first observation that "…some potent implicit common factors, perhaps more important than the methods purposely employed, explained the uniformity of success of seemingly diverse methods" (p. 453). Having uttered these words in 1936 (Sparks et al., 2008), Rozensweig's insights fuelled enquiry into the common factors of psychotherapies only much later.

In unison with Rozensweig's suggestions, a presentation at the 1940 conference of the American Orthopsychiatric Society outlined four areas common to the diverse theoretical approaches that inform psychotherapy: "…having similar objectives, making sure that the relationship is central, keeping the responsibility for choice on the client, and enlarging the client's understanding of self" (Sparks et al., 2008, pp.454-455). From these early observations in psychotherapy outcome research the idea evolved that diverse theoretical approaches differed more in theoretical content, but that the underlying process of change is common to all.

Subsequent comparative studies lent increasing support to the idea of common factors that thread through diverse models of psychotherapy (Sparks et al., 2008). Notable contributors include Heine (1953) who emphasised therapist characteristics; Fiedler (1950) on the ideal therapeutic relationship; Hoch (1955) lamenting the role of methods of influence; Garfield (1957) shining light on the impact of catharsis and opportunity for new understanding; and even Carl Rogers (Sparks et al., 2008) who cemented the idea that "the therapist-provided variables were "sufficient" for therapeutic change", referring to the therapist's role in creating an interpersonal space characterised by "empathy, respect and genuineness" (p.456).

Over time and with increasing empirical fervour in the domain of common factors research, Sparks et al., (2008) described how the necessary elements of effective psychotherapy came to be defined in clearer and more sophisticated terms than before. Various researchers started outlining comprehensive models of a psychotherapy based on common factors. Frank (1973) provided an account of how common factors in psychotherapy (including healing practices beyond the westernised concept of psychotherapy, such as traditional healing) affected the underlying process of behaviour change. Researchers in the field (E.g. Fourie, 2012; Norcross & Newman, 1992; Sparks et al., 2008) then also credited Frank's account as having incorporated the role of client expectancy as an important factor in effective psychotherapy. Norcross and Newman (1992) point to the importance of Frank's observation that "all psychotherapeutic methods are elaborations and variations of age-old procedures of psychological healing" (p.10) and that there is in fact nothing new under this sun.

Given the amount of research and the variety of opinions on common factors, it is no surprise that the number of factors proposed to be common to effective psychotherapies have accumulated into impractical proportions. This is reflected in research papers that express criticism, and perhaps, scepticism of the common factors movement. For example, *Where are the commonalities among therapeutic common factors?* by Grencavage and Norcross (1990).

These authors reviewed 50 studies that outline common factors and found that "the number of factors per publication ranged from 1 to 20, with 89 different commonalities proposed in all" (p. 372).

As a result, common factors theorists have turned to grouping factors together in what can be seen as meta-factors. For example, Duncan and Reese (2013) outline Duncan's model of five common factors (Fig. 2.1), including extra-therapeutic and client factors (87%); and treatment effects (13%)[1] that are subdivided into the remaining four common factors: Therapist effects (46-69%), alliance effects (38-54%), technique-specific and expectancy effects (30%), and feedback effects (15-31%).

In Duncan's model, client and extra-therapeutic factors include the client's worldviews, strengths, struggles, motivations, distress, supportive relationships as well as unexplained variance (Duncan & Reese, 2013). Therapist effects refer to characteristics of the therapist that impact on therapeutic outcome and represents the second most influential factor, whereas the therapeutic alliance represents the third most important factor and one of the best predictors of outcome. Technique specific factors include those aspects general to all methods of treatment such as the model's rationale, the explanation offered for the problem as well as scripts that are followed to address the problem.

In their explanation of the latter process Duncan and Reese (2013) are of the opinion that "[m]odels achieve their effects…*through* the activation of placebo, hope, and expectancy, combined with the therapist's belief in (allegiance to) the treatment administered" (p. 500). Regarding the final factor, it is believed that client feedback provides necessary information to

[1] Of the overall outcome of psychotherapy, Duncan's model proposes that client and extra-therapeutic factors account for 87% of behaviour change, whereas the remaining four common factors, collectively known as the treatment effects, account for only 13% of the overall outcome of psychotherapy.

the therapist regarding therapeutic outcomes and expectations so that the therapist may timeously adjust the treatment as needed.

When seen as a holistic, interactive/reciprocal process, common factors models encapsulate much of social constructionist conceptualisations of the therapeutic process (Fourie, 2012). For instance, social constructionists would say that the client and therapist are constantly exchanging ideas about the problem as informed by their individual characteristics, expectations and guiding model, thereby providing each other with constant feedback and constant opportunity to adjust their explanations of the problem with concomitant possibilities for new or different actions.

Although Duncan and Reese (2013) do emphasise the interdependence and interplay of the various common factors, attention is explicitly drawn to the "disproportionate influence" of the client on therapeutic outcome (p. 498). Understandably, clients as a result of their individuality, differ in huge ways and thus what is worked on in the context of psychotherapy is chiefly determined by the client's unique characteristics and support structures.

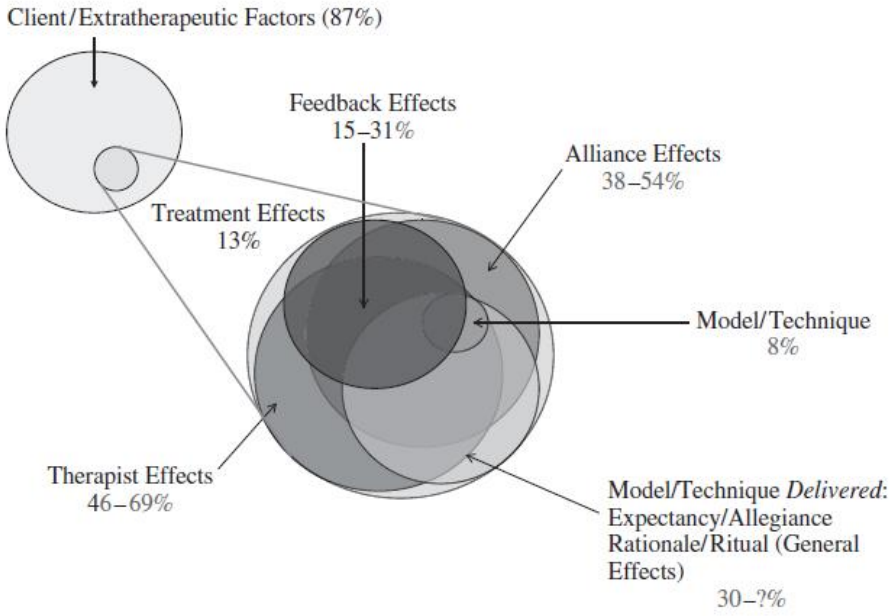

Figure 2.1 Duncan's Common Factors (Reprinted from Duncan & Reese, 2013, p. 498)

However, when a client comes to therapy, it is unlikely that they purposefully bring these variables along and these factors are likely to be un-mobilised as change factors prior to therapy. Therefore, although the client contributes 87% of what is useful to the outcome of psychotherapy, it can be argued that, that 87% was likely not useful to effect the desired change outside the context of psychotherapy, as otherwise the client would not have sought the help of a psychotherapist.

By illustrating the commonalities of effective psychotherapists, the common factors movement has added much to our understanding of what contributes to effective psychotherapy (Fourie, 2012). This has led to various strategies of how to conceptualise the process of psychotherapy (Norcross & Newman, 1992). In fact, Norcross and Newman (1992) emphasise the fact that common factors therapists function on the level of clinical strategy and are guided by the change process rather than by a theoretical abstraction or by recipes based on specific techniques. Given its bird's eye view of therapy models and techniques, it's 'meta perspective' provides common factors therapists the luxury of selecting what works best from all the different approaches and perhaps even to integrate all that seems different about psychotherapy approaches.

2.5 PSYCHOTHERAPY PROCESS vs VARIABLES OF CHANGE

More recently, the common factors movement has become defined as a meta-theoretical approach to conceptualise effective psychotherapy (Norcross & Newman, 1992; Sparks et al., 2008). Given escalating empirical proof that the bulk of the active ingredients of psychotherapy transcends any specific theoretical approach or technique of psychotherapy (in the form of therapist, client and extra-therapeutic variables), proponents of the common factors movement

have in some ways abandoned close-knit alliances to specific theories and models of psychotherapy.

Norcross and Newman (1992) also attach weight to the "...dissatisfaction with single-school approaches and a concomitant desire to…see what can be learned from other ways of thinking…" (p.4) as contributing to the development of a common factors movement. The common factors trend, then, is closely associated with eclectic and integrative psychotherapy approaches that seek to combine the best elements of varied and epistemologically incongruent therapy models (Norcross & Newman, 1992; Sparks et al., 2008).

Eclectic and integrative approaches differ chiefly on the value their proponents attribute to the role of theory in psychotherapy outcomes (Norcross & Newman, 1992). According to Norcross and Newman (1992) eclecticism can be defined as the pursuit of the best technique or model for the specific person and problem at hand. The selection of the therapy technique to be used is based on predictions of its efficacy for the specific client and problem and is reliant on "…data on what has worked best for others in the past" (p. 11).

Proponents of eclecticism place little emphasis on the guiding belief systems that inform the techniques of specific models and rely instead on the outcomes of techniques to make decisions on its applicability. Thus, implicitly or explicitly, technical eclectics are guided by positivist worldviews that suggest that empirical data should guide the therapist's selection of techniques, and is probably the closest approximation of EST approaches to psychotherapy.

Integrative psychotherapy, on the other hand, can be defined as the integration of "…two or more therapies…in the hope that the result will be better than the constituent therapies alone" (Norcross & Newman, 1992, p. 11). Thus, rather than simply adding components of therapies together, the integrative approaches also attempt to integrate the theories that guide varieties of psychotherapy models. Norcross and Newman (1992)

emphasise the commitment to "…[synthesise] the best elements of two or more approaches to therapy…[and seek] an emergent theory that is more than the sum of its parts…" (p. 11-12). A glaring assumption of the proponents of integrative approaches then is that existing models and theories of psychotherapy are inadequate to effect the desired behaviour changes and thus need to be enhanced into 'super models' of psychotherapy by changing its epistemological building blocks.

Since proponents of the common factors movement are intent on elucidating the basic ingredients of effective psychotherapy across various and differing models and theories, Norcross and Newman (1992) describe common factors as a third avenue towards psychotherapy integration. The eventual result of common factors research is believed to be the creation of "more parsimonious and efficacious treatments based on…commonalities" (Norcross & Newman, 1992, p.13). In pursuit of its promise of providing a meta-theory of psychotherapy change, it is envisioned how common factors and model-specific factors can be integrated to provide the best treatments for specific clients with specific disorders (Norcross & Newman, 1992).

According to Norcross and Newman (1992) integrative approaches to psychotherapy have shown unprecedented growth in interest since the 1980's due to factors such as sheer mass of therapeutic models (over 400), inadequacies of single theories, demands to illustrate psychotherapy effectiveness and clearly described procedures, interest in brief solutions and exposure to other models of understanding, and finally mounting evidence to support the dodo bird verdict. Probably the most important organising factor of the common factors movement has been its institutionalisation in the form of professional networks, such as the Society for the Exploration of Psychotherapy Integration (SEPI), that serve to legitimate the common interest of integration- and common factors fanatics (Norcross & Newman, 1992).

However, as Fourie (1992) points out there have been considerable critiques of the common factors movement (as will be discussed later in this chapter).He is of the opinion that, while contributing much to our understanding of what is necessary in effective psychotherapy, having knowledge of common factors is not sufficient for effectively practicing psychotherapy.

Norcross and Newman (1992) acknowledge the limitations of common factors, but contend that with further empirical research and painstaking commitment, the field of psychotherapy will eventually converge to a point where psychotherapists and systems of psychotherapy grow to be more similar as they discover their commonalities and integrate their differences. These authors are of the opinion that the path to integration includes recognition of the complementarity of seemingly opposing models of psychotherapy; of the interplay between cognition, behaviour and affect; of the need for empirical validation of treatments and the need for a common language for psychotherapy.

In order to achieve the goal of integration, the strategy of common factors proponents has been clear: Emphasise its potential, illustrate the relatively unimportant role of theoretical models[2], and spread the gospel to all corners of the psychotherapy world. This is illustrated in suggestions by common factors proponents (Sparks et al., 2008) of how even family therapy and social work could stand to benefit from the wondrous discoveries and insights of the common factors movement, a strategy that seemingly has paid off.

The field of family therapy has for long emphasised the relational aspects of psychotherapy (Becvar & Becvar, 2000) and with the epistemological shift from observed systems to observing systems the focus shifted from family members' worldviews alone to

[2] Some estimate its contribution to the outcome of therapy to be as low as 1% (Wampold cited in Sparks et al., 2008).

include the therapist and his or her worldviews as central to the psychotherapy process (Checchin, 1992; Frugerri, 1992; Van Zyl, 2009).

Recent dialogue in family therapy journals show that common factors concepts such as therapist-client worldview matching (Blow, Davis & Sprenkle, 2012), the role of the therapist in common factors (Simon, 2012a) and effectiveness of therapists (Simon, 2012b) are currently hot topics for debate in the family therapy field. Common factors theorists advocate that their approach is not only compatible with the epistemologies that guide social work and family therapy, but essential to it (Drisko, 2004; Sparks et al., 2008).

Seemingly then, the all-pervasive common factors movement offers redemption to the adversarial field of psychotherapy by proposing a pan-theoretical view of psychotherapeutic change. No longer do psychotherapists need to be confined by the limits of their theories and models. In fact Norcross and Newman (1992) emphasise how common factors therapists function on the level of clinical strategy and are guided by the change process rather than being restricted by theoretical abstractions or recipes from specific techniques. Despite currently offering little in the form of a satisfactory conceptualisation of the change process, common factors proponents believe that their approach offers the chance to sample everything and use what works, even if it means mixing and matching different techniques from different models. After all, the common factors movement has 'empirically' proved that it is not your models or techniques that matter, but rather mostly your client's- and then some of your factors that do.

2.5.1 Client- vs. Therapist Factors

Handbooks on integrative and eclectic psychotherapy (Norcross & Goldfried, 1992; Prochaska & Norcross, 2010) stress the importance of psychotherapists understanding the process of change. Therefore techniques and models are employed as deemed necessary by the

therapist to achieve the main goal and to affect behaviour changes as requested by the client. As such the common factors movement does not offer any "specific frameworks of client personality or psychopathology as empirically correlated with outcome, but affirms the preeminent role of nonspecific client factors across therapies and *self-generated* change" (Own emphasis added, Sparks et al., 2008, p. 460). The latter quote encapsulates the general assumption of common factors theorists of a client-centric instead of a therapist-centric process of psychotherapy.

As the impact of client- and external factors on the outcome of behaviour change is estimated to range between 40% and 87%, the client himself or herself is framed as the catalyst for change, whereas the therapist plays merely a supportive role (Sparks et al., 2008). The latter authors quote Prochaska, Norcross and Di Clemente who suggest that "…it can be argued that all change is self-change, and that therapy is simply professionally coached self-change" (p.460).

Although Prochaska et al.'s view on the impact of therapist contributions to outcome is somewhat unflattering to psychotherapists with their many years of training, it is definitely not a ground-breaking view. In fact, Humberto Maturana had similar ideas already in 1975, when he coined the term structural determinism (Maturana, 1975). Being a biologist, Maturana made the observation that any biological organism can change only so much as its biological structure allows it to change. Translating this to psychological terms, it means that any change that occurs in human beings is primarily due to their biological structure allowing them to change, and thus a therapist cannot change clients when their biological and/or personality structures do not allow them to change.

Of course, Maturana also understood that organisms do not exist in a narcissistic vacuum, and thus added the concept of structural coupling to his theory of change (Maturana,

1975). Although the limits of change is set by an organism's biological structure, Maturana noted that change occurred with the introduction of difference through contact with environmental or other biological structures. Structural coupling then simply means that for one structure to affect an influence on another structure, those two structures need to couple in a way that makes change possible. In psychological terms, structural coupling suggests that a client will not change if there is no coupling with another structure that carries news of difference (such as a therapist or an environmental event that serves to disturb its status quo).

Consider the soccer ball as an example of this concept. A soccer ball's structure is such that if the right amount of force is applied to it, it can become buoyant (it is structurally determined in such a way). A human foot's structure is such that it can apply only a certain amount of force without disintegrating (it is structurally determined that way). When you couple the foot's structurally determined amount of force it can exert to the soccer ball's structurally determined buoyancy potential, it allows the foot to influence the ball in such a way that it bounces off the foot to move in a given direction. Maturana would say that the two are structurally coupled in a way that affects change[3] (i.e. the ball moving in a given direction).

If the foot, however, were coupled with a one ton cement block, it would result in the foot disintegrating, since the cement block's structure is such that it does not become buoyant with the amount of force the human foot can exert. Thus, the foot and the cement block are not structurally coupled in a way that allows the block to be moved in a specific direction. They are, however, coupled in a way that leads to the disintegration of the foot (as a result of the limits set by its structure).

The work of Maturana lent critical support for second-order family therapists' and later social constructionist psychotherapists' work on the negotiation and co-creation of new

[3]Also see the works of Karen Barad (2004) on relational ontology, as discussed briefly in Chapter 7.

understandings of old problems that are equally reliant on the dialogical interaction between client and therapist (see Andersen, 1992; Anderson & Goolishian, 1992; Anderson, Goolishian & Winderman, 1986; Checchin, 1992; Efran & Clarfield, 1992; Efran, Lukens & Lukens; 1990; Fourie; 1994; Fourie, 2012; Frugerri, 1992; Hoffman, 1992; Minuchin, Nichols & Lee, 2007).

However, as mentioned before, common factors researchers' interpretations of empirical findings imply that client factors contribute more than therapist and/or technique-specific factors to the outcome of psychotherapy. Thus, owing to the client's major influence in psychotherapy, Sparks et al., (2008) define their model of common factors as a client-directed, outcome-informed (CDOI) approach and suggest that it…

> *…takes advantage of the extant literature on the role of nonspecific factors, particularly client variables and engagement via the therapy alliance, client perceptions of early progress and the alliance, and known trajectories of change. As such it is more about change than about theoretical content* (p.459).

If client and external factors make up the best part of the factors responsible for change, then one may ask why the therapist is paid? Frank and Frank (1991) describe the therapist's role as one of providing the client with a healing alliance as well as selecting a therapeutic model that best fits with that client's characteristics and worldview. The latter notion of worldview matching has also surfaced as a hot debate in family therapy journals, e.g. *The Journal of Marital and Family Therapy* (see Blow et al., 2012; Simon, 2012a; Simon, 2012b).

Various authors (Norcross & Newman, 1992; Sparks et al., 2012) agree that besides the client- and external factors, the therapeutic alliance is the most important factor predicting behaviour change. As mentioned before, Carl Rogers' idea of empathy, respect and honesty as

being necessary for successful psychotherapy is a case in point. Fiedler (1950) also concluded in his classical study that there is little difference in the nature of the ideal therapeutic relationship as described by experts informed by divergent theories of psychotherapy.

One of the major tenets argued in the current thesis is the idea that the therapist's contribution lies in his or her ability to facilitate a negotiation of a new narrative framework of the problem that allows for the mobilisation of dormant common factors, including client- and external factors. To achieve this, it becomes important for the therapist to reflect not only on what the client contributes, but also on what he or she contributes to the therapeutic relationship, and more importantly how he or she contribute it.

Again this reflexivity on the part of the therapist has been emphasised extensively by eco-systemic, constructivist and social constructionist researchers (e.g. Andersen, 1992; Anderson & Goolishian, 1992; Anderson, Goolishian & Winderman, 1986; Checchin, 1992; Efran & Clarfield, 1992; Efran et al., 1990; Fourie; 1994; Fourie, 2012; Frugerri, 1992; Hoffman, 1992; Minuchin et al., 2007).

The reflexivity on self and the therapeutic relationship as emphasized by eco-systemic and social constructionist authors have focused on the collision of differences between client and therapist worldviews, suggesting that the therapist needs to provide something sufficiently different, but not too different, in order to impact optimally on the client (Efran & Clarfield, 1992). The goal of psychotherapy, irrespective of model used, would then be for the client and therapist to renegotiate, in interaction with each other, the parameters of the client's problem (some would say to re-story a problem to allow for solutions to become apparent).

This social constructionist idea of psychotherapy suggests that the differences between divergent theories of psychotherapy may be quite superficial and that the potent element (i.e. the co-constructing interaction via language and discourse) is facilitated by the therapist's

attitude towards the interaction that brings news of difference. In Hill's (1995) words: "…there is a general equivalence of mechanism [among differing psychotherapy models] despite the superficial nonequivalence of content" (p. 87).

Fourie (2000) outline such a social constructionist conceptualisation of therapeutic change that includes elements of a cognitive reframe followed by therapeutic action that is coherent with this reframe and stresses that such a reframe stems from the dialogical process between therapist and client. In order to reach a reframe, the therapist enters into a dialogical interaction with the client on the meaning of the problem and bargains on the difference of his or her understanding (embodied in his or her therapeutic model or technique) to that of the client's original understanding, that together form a new co-created understanding of the problem.

This new understanding then informs different paths to solution and behaviour change that are incorporated into a therapeutic ritual or activity (such as therapeutic techniques, prescriptions, etc.). The therapeutic relationship then is not just a relationship, but a relationship context that is characterised by *orthogonal interaction* and 'brings news of difference' (Efran & Clarfield, 1992)

While rejecting the medical model (e.g. EST and EBPP) that suggests that psychotherapy occurs in distinct phases, Sparks et al., (2008) make the observation that therapy from a common factors perspective operates in an altogether different paradigm, what they call a *common factors paradigm*. Due to its different conceptualisation, common factors psychotherapy does not lend itself to a therapeutic recipe approach, but rather a "fluid… always unique collaboration between client and therapist" (Sparks et al., 2008, p.465).

However, as it was described above, the common factors movement understanding of psychotherapy and the therapeutic alliance is somewhat different from the eco-systemic and

social constructionist understandings. Although these approaches all reject the medical model, a common factors view of successful psychotherapy is when the client cures him or herself by utilising whatever therapy offers, and the therapeutic alliance is lineal in that the therapist's role is to offer a congruent model and support while trying not to get in the client's way of healing (Sparks et al., 2008).

The therapist is taught as many techniques and worldviews as possible so that he or she may change colours like a chameleon in order to adapt to the client's view of things. The interaction then becomes less of an exchange and negotiation of worldviews than a customer satisfaction mission. This is perhaps best illustrated in Sparks et al.'s (2008) description of the therapeutic process:

> *…CDOI practitioners collect feedback data from the first session and through subsequent sessions to determine if therapist provided variables, including method and intangibles such as warmth or professional demeanor, fit with client views and expectations* (p.465).

With their interpretations of empirical findings it seems then that common factors theorists and practitioners have fixated on factors and ingredients and their relative contributions to outcome. Thus, the client as person have been confused with client factors and the therapist as person with therapist factors.

The process of interaction between therapist and client has been reduced to alliance factors and the importance of each in the therapeutic interaction has been reduced to the empirical percentage of their contributions to outcome. Therefore a good therapist in common factors language (e.g. CDOI-approach) is one that knows how little he or she contributes to psychotherapy, that is less than 13% (Duncan & Reese, 2013), and how much he or she should

yield to client preferences or worldviews due to the exorbitant influence of client factors on psychotherapy, that is up to 87% (Duncan & Reese, 2013). As Fourie (2012) would comment, meaningful (or meaning-making), equitable human dialogue between client and therapist has been overlooked.

2.6 CRITIQUES OF EST'S, EBPP AND COMMON FACTORS

As with any scientific endeavour, progress in understanding is facilitated through critique of a theory's shortfalls. This section summarises various critiques of the evidence based and common factors movements. These critiques highlight not only methodological concerns with these approaches, but also question the philosophical assumptions on which these endeavours are based.

The first point of critique against evidence based movements surrounds the question as to what constitutes evidence. As pointed out earlier in this chapter, ESTs demand the use of empirical evidence to validate specific treatments for specific disorders, whereas EBPP advocates for the use of best available research in clinical decision-making. Drisko and Grady (2012), however, point out that EBPP hierarchies of evidence emphasise empirical evidence (i.e. experimental designs), which may reinforce ideas of its superiority over other forms of evidence.

Stuart and Lilienfeld (2007) further point out critiques that echo the concern that empirical evidence based on laboratory research may not be appropriate when applied in a community setting due to differences in characteristics of the populations. Among these differences is the fact that community populations often have numerous comorbid difficulties, whereas ESTs usually rule out participants who do not have clear-cut single diagnoses (Sparks, Duncan & Miller, 2008). Furthermore, Whaley and Davis (2007) cite research that bring into

question the cultural sensitivity and/or competency of the treatments identified as evidence based and report that research samples used in EBPP and EST outcome studies are very seldom ethnically and racially diverse.

Although the EBPP approach is more inclusive of what constitutes as evidence, Stuart and Lilienfeld (2007) remark that this approach is not clear enough in defining what it means by evidence and also that it offers no clear criteria for differentiating between treatments that are evidence based and those that are not. Furthermore, Klein (2002) is of the opinion that the "…weak criteria chosen for demonstrating evidence-based psychotherapy benefits would allow both prayer and EMDR to be considered validated treatments" (p. 29).

As a result of the stated weaknesses Stuart and Lilienfeld (2007) highlight that there is a double bind engendered in the EBPP approach: "Finding the most substantiated treatment with the most generalizable application may be as impossible as finding the deepest lake at the highest altitude" (p. 615). They also argue that the EBPP approach does not provide guidelines related to potentially harmful treatments, including emotionally expressive therapies and crisis debriefing. As a potential solution, Stuart and Lilienfeld (2007) propose that treatments be plotted on an effectiveness-harmfulness continuum based on the strength of the evidence that support either its benefits or potential danger to clients' mental health.

On the topic of experimental evidence, Lindegger (2007) outlines and critically discusses various approaches that are aimed at establishing best practice guidelines for psychotherapy, among which include double blind randomised designs, experimental designs, correlational designs, etcetera. Although these may be ideal approaches for researching clinical/medical settings, Lindegger (2007) recognises important limitations to these approaches when they are applied to psychotherapy research. Among the limitations are researchers' difficulties to separate the active ingredients of psychotherapy from non-active

ingredients; and the difficulty of attributing the outcome of treatment to therapist skill versus effectiveness of the specific approach.

To address these limitations, newer empirical approaches have been proposed. These include using therapy manuals to control for therapist skill and "dismantling" techniques (Lindegger, 2007, p. 466) that systematically remove certain components of an approach to ascertain which of these actively contribute to therapeutic change. These proposed solutions, however, do not address the more basic critique against evidence-based movements (i.e. its unwarranted philosophical assumptions that are projected as truths).

The first of these unwarranted assumptions relate to the assumption that all evidence is empirical evidence. Wendt and Slife (2007) have the following to say in this regard:

> *The failure to consider a philosophy of science perspective led the Task Force [on EBPP] to make a number of epistemological assumptions that are not based on evidence or rationale and that thus violate the very spirit of evidence-based decision making…The Task Force's grand assumption, underlying all the claims of its report, is that "evidence" equals "empirical."* (p. 613).

They go on to illustrate the logical flaw contained in the reasoning upon which the EBPP approach is based by pointing out that EBPP calls for evidence to promote the transparency of psychological treatment, but does not provide evidence (and thus not transparency) to justify empiricism as the methodological method of choice to establish the effectiveness of any specific method.

Furthermore, Wendt and Slife (2007) critique the EBPP definition of qualitative evidence in that…

> *…it tends to assume that all alternative methods [of research] are variations on the same empiricist epistemology…[and that] it fails to understand and value qualitative research as a different philosophy of science* (p. 613-614).

By constricting the contribution of qualitative methods as providing 'subjective' evidence only, Wendt and Slife (2007) argue that they are demoted as an inferior source of evidence to empirical methods that are assumed to provide 'objective' and therefore 'more valuable' evidence. However, the objectivity of empiricism as a method of inquiry in psychology can be debated in, and of, itself (see Wendt & Slife, 2007).

To illustrate the arguments proposed above, the reader is invited to consider the following. If the research question is framed as: 'What makes therapy work?', then one needs to take into account that there are different approaches to psychotherapy that are informed by different philosophical worldviews regarding what effective psychotherapy entails. These include positivist epistemologies as well as epistemologies based in the postmodern paradigm such as constructivist- and social constructionist epistemologies.

Should one frame the solution to the research question as: 'Only therapy that is empirical (i.e. validated by experiments) equals therapy that works' then one argues from within a specific frame (a positivist frame), but reaches a conclusion that sweeps across various frames in its implications. Thus, one can accept that the conclusion may be valid in a positivist frame, but it can be totally invalid in a social constructionist frame, as these frames have different guiding principles.

Terre Blanche and Durrheim (2006) refer to Thomas Kuhn's work on paradigm shifts to highlight the logical flaw referred to above:

> *Because paradigms differ in terms of the questions they consider legitimate and the scientific methods they endorse, there is no way of empirically adjudicating between them - they are said to be 'incommensurate', meaning...they simply talk past one another* (p. 5).

Thus endorsing empiricism (a positivist value) as the key means of adjudicating between positivist and postmodern therapeutic approaches, is similar to the pigs declaring yard Olympics to decide which of all the animals can 'oink' the loudest.

The second unwarranted assumption of evidence based approaches that is questioned is the idea that a therapeutic technique, or some active ingredient it contains, is responsible for the effectiveness of psychotherapy. On this topic, Fourie (2012) elaborates on how evidence based movements and common factors theories' reliance on positivistic/empirical underpinnings lead to the unwarranted equation of psychotherapeutic interventions (talking cures) to pharmacological interventions (biochemical cures).

Specifically, Fourie (2012) and Hunsberger (2007) argue that the tendency to equate therapy with pharmacological interventions is flawed in that it supposes that the power of psychotherapy lies in the approach itself, and thus seeks to reduce the mechanism of change to that 'magical active ingredient' inherent in the approach. This in positivistic thinking is termed essentialism (Parker, 2001; Carr, 2006).

Whereas common factors researchers seek to address the limitations of evidence based approaches by discovering the common elements that contribute to effectiveness of various psychotherapy models, this approach has also been widely criticised. The critique on this movement also fall into two categories: Methodological- and research issues and epistemological issues.

With regards to issues related to research methodology, Chambless (2002) points out that the common factors movement's claim of generally equal effectiveness of psychotherapy across various models is based on questionable research methodology. Specifically she is of the opinion that conclusions that support the dodo bird verdict are based on overgeneralised findings from meta-analyses.

Schneider (2002) on the other hand is of the opinion that common factors research relies heavily on meta-analyses and experimental research designs and argues that more nuanced qualitative research is required in order to make sense of clients' experiences of smaller (statistically insignificant) differences in outcomes. According to Schneider (2002):

> *It is precisely by looking more closely that outcome research will stretch beyond the merely apparent and reach into the tacit, affective, and existential. These are the domains that arguably matter most to clients, but are rarely queried in mainstream clinical research* (p. 26).

Beutler (1995) comments on the tendency of common factors approaches to result in poorly delineated lists of common factors that vary considerably from one approach to the next. He further remarks that: "…identifying any set of [common] variables does little in the way of identifying what aspects of the therapist's behavior and therapeutic intervention give rise to them" (p. 79).

With regards to the latter critique, Arkowitz (1995) remarks on the fact that common factors tend to be taken out of context rather than being seen to comprise a complex, interrelated interactive process. Arkowits (1995) identifies the need for a theory of the processes of change that would serve to tie various common factors together in a meaningful way. This need is echoed by Hill (1995) who states the following: "before we can make statements about whether

common factors or specific factors are more important in leading to change…[we] need to determine how any factor operates to lead to change" (p. 89).

With regards to philosophical critiques of common factors, a recent debate that was carried out in the Journal of Marital and Family Therapy illustrates how family therapists (and other common factors proponents) are walking into the logical mess created by a positivist privileged stance. The mentioned debate centres around the question of which is more important: That the family therapist work from a model *whose* worldview matches his/her own worldview or choose a model *whose* worldview matches that of the client (Blow et al., 2012; Simon, 2012a & 2012b). While both parties argued compelling points for either of the positions, they failed to recognise that they are engaging in a basic logical flaw: Personification of the model as an agent engaging in the therapeutic process.

Notice the framing of the debate above and the necessity of using the pronouns 'whose' to refer to the model's worldview, suggesting that the therapeutic model itself is personified and able to possess a worldview. This personification of the model points again to the positivist concept of essentialism, as if the model itself essentially possesses that worldview. Moreover, the idea is created that the model itself is actively engaging with the client through its worldview, instead of just being a source of concepts and metaphors that the therapist can utilise to inform his or her worldview while engaging with the client.

Thus, from a social constructionist viewpoint one might say that the author who proposed the model, framed that model from his or her worldview, and subsequent users of that model interprets and frames that model from their personal worldviews. In this sense then one can see how the mixing of paradigms (i.e. using positivist concepts to solve problems emanating from a different worldview) spawns various theoretical problems.

This leads to a general critique of the common factors movement and its tendency to divide the holistic interactive process of psychotherapy into underlying factors (also see Castonguay & Holtforth, 2005). Here the reader is referred to Fig 2.1 above. Notice that the factors are divided into client factors and then a blob of other factors that are said to interact to affect the outcome of therapy. A peculiarity of this model is that the therapist as a factor is muddled into this blob of common factors, creating the idea that he or she plays an auxiliary role in the therapeutic process, one of the factors that the client can utilise in his or her recovery process. This is exemplified in the CDOI approach of Sparks et al., (2008).

The problem with this conceptualisation is that one of the two main agents in the therapeutic process (i.e. the therapist) is relegated to the role of a subsystem (or sub-factor) along with the other impersonal factors (such as technique, alliance, feedback, etc.). The therapist then is underestimated as being one of the elements of therapy that the client uses rather than the other player or agent in therapy with whom the client interacts. This critique is addressed in the next two chapters where a revised model of common factors is proposed by drawing on concepts of social constructionism and eco-systemic psychotherapy.

2.7 Conclusion

Despite many critiques of the evidence based and common factors movements, it is acknowledged that these have contributed to the knowledge and understanding of psychotherapy. Whereas the views expressed in this thesis are guided by a critical postmodern, social constructionist worldview, it is also acknowledged that critique without proposed solutions is not constructive. Therefore, the chapters that follow serve the purpose of elucidating aspects of the postmodern paradigm as well as insights from a social constructionist

epistemology that may contribute to further our understanding of the process of change that occurs in effective psychotherapy in order to address some of the shortfalls identified above.

This will include a reconceptualisation of the common factors model by drawing from social constructionist and family systems ideas and concepts, as well as illustrations by means of therapeutic formulations/clinical vignettes of how specific models may be utilized in this social constructionist model of therapeutic factors.

CHAPTER 3

SOCIAL CONSTRUCTIONISM AND COMMON FACTORS[4]

As illustrated in the previous chapter, common factors models of psychotherapy have various limitations, some of which stem from paradigmatic assumptions, and which provide very limited guidance regarding the change process in psychotherapy. As there is no clear conceptualisation of how common factors may interact to give rise to a process of change, therapeutic activity from a common factors perspective runs the risk of being poorly integrated. It is also a point of critique that its lack of a guiding conceptualisation of a change process raises questions of the legitimacy of clinical decisions (see Chapter 2).

As pointed out previously, common factors models tend to list and group common factors into meta-categories of factors with statistical data regarding each factor's contribution to overall behavioural change. Although it may be beneficial for research purposes to know how much each factor contributes to the overall outcome of psychotherapy, it is argued here that such statistics are of little use when a therapist is engaged in the practice of psychotherapy. In fact, such statistical data may even create the impression that some factors should be considered as being less important than others, as is the case with technique- or model factors (Duncan & Reese, 2013; Sparks et al., 2008).

It is argued here that conclusions based on the statistical contribution of factors to general therapeutic outcome may lead therapists to underestimate the importance of some factors in specific therapeutic cases while they are focussing on those factors with the highest

[4] Parts of this chapter has been adapted from a chapter that appeared in the author's unpublished mini dissertation titled R*eframing diagnostic labels as interpersonal metaphors: A social constructionist perspective* (Van Zyl, 2009). These parts were rewritten and adapted to be relevant to the current topic.

statistical values. Also, as argued in the previous chapter, the statistical impression of the client contributing up to 87% to the overall therapeutic outcome leads to curious conclusions regarding the role of the therapist. In the CDOI approach to psychotherapy (Sparks et al., 2008), for instance, it is suggested that the client contributes most of the change factors and thus affects 'self-change' while the therapist's role is to support and get out of the way.

Such a lopsided concept of the therapeutic interaction may undermine what Fourie (2012) calls 'the dialogue' between client and therapist. Symbolising more than mere verbal exchange, Fourie's use of the term *dialogue* refers to the co-construction of new ideas about, and different paths to, the solution of the therapeutic problem as initially defined by the client himself or herself. This latter process counts on an equitable exchange between client and therapist that is not served by a general attitude of submissiveness to client demands[5].

Therefore, as a means to address such unfortunate conceptions of the therapeutic relationship that may stem from current models of common factors, this chapter explores concepts and ideas about change that are based in a postmodern paradigm, specifically eco-systemic and constructivist theories. From these considerations, it is proposed that the common factors model be reconceptualised as a multi-systemic model with the client and therapist as reflecting agents, reflecting on themselves and their alliance as factors, among other sub- and supra-factors, including technique factors. In such a model it will be illustrated that the therapist as a person-factor alongside the client as a person-factor constitute the two most important factors in the therapeutic supra-system[6].

[5] Reflexivity from a social constructionist view suggests that any therapist attitude (including submissiveness to client demands) may be beneficial to therapeutic outcome if this therapist attitude is adopted reflexively and purposefully (Hoffman, 1992). Such reflexivity allows the therapist to introduce specific interactive dynamics to the therapeutic interaction so that its meaning may be reflected on negotiated to bring about new meaning.

[6] The concept of two or more individuals forming a therapeutic supra-system through their interactions and reflections is well documented in family therapy literature. See Becvar & Becvar (2000) for further information on this topic.

3.1 INDIVIDUALS AND CONTEXT: IS THERE SENSE IN REDUCTION?

According to Efran et al. (1990) empirical conceptions of psychological cause-effect chains:

> *…can be an unproductive mental game. Often we don't need to traffic in causal attributions at all. We know what we like even when we don't know why we like it. We know that when our brother was late, we got upset. We also know that when he apologized in a particular way, our distress vanished. That much we can be certain of, and it is important. The rest is often idle inference* (p. 101).

Furthermore, Efran et al. (1990) demonstrate how causes and effects are constructed in conversation whereby phenomena (including lived experiences) are subdivided into parts (Lifschitz & Fourie, 1990). As a result, the empirical notion that social experience and social living exist with special laws determining that event A would lead to outcome B is problematic from a social constructionist perspective (Fourie, 1994).

Many post-modern theorists (e.g. Lifschitz & Fourie, 1990) are of the opinion that social systems constitute whole systems (meaning that causal chains are purposeless due to the understanding that its creation inexorably leads to tautologies. Said differently: "[a] description is turned into a purpose that is then asked to account for the description" (Efran et al., 1990, p. 99). For instance, a child that is considered to have a learning disorder may find that his mother, bearing in mind his difficulties, takes it upon herself to ensure that his homework is done and that he has the right materials to study for tests. He may thus become used to the level of assistance he receives from his mother and never develop the skills and autonomy to

successfully master his schoolwork. The diagnosis communicates a 'state of affairs' that sets in motion an interactional pattern that reinforces or even creates that feared state of affairs.

Due to the problems associated with causality in the realm of human relationships and behaviour, a different worldview is embraced by many social scientists in an attempt to transcend these empirical pitfalls. This different worldview conceptualises our social reality in terms of wholeness and context (hence its name eco-systemic epistemology) and is a product of a wider ontological shift known as postmodernity.

3.2 POSTMODERNISM: A CONTEXT FOR SEEING PEOPLE IN CONTEXT

According to Sey (2006) "postmodernism is a broad term for many different approaches that set themselves up in opposition to the coherence and rationality of the modern world" (p. 524). Modernist approaches (such as empiricism), which emphasise the scientific endeavour for discovering ultimate truths, is fundamentally based on the assumptions that observers of social reality can bypass their subjectivity and view the world in a direct, objective and value-free manner via their senses (Fourie, 1994; Sey, 2006; Von Foerster, 1984).

Postmodernism, however, is critical of the modernist assumptions that promote the concept of one truth. Instead, the movement seeks to recognise the opportunities that result from embracing multiple and relative truths. Furthermore, these multiple social truths are assumed to be the products of the meanings that people attribute to events through the medium of language (Sey, 2006).

3.3 ECOSYSTEMIC EPISTEMOLOGY AND SOCIAL CONSTRUCTIONISM

When considering eco-systemic theory, it is important to understand the concept of second-order cybernetics that suggest that a system (such as a group of friends or a client and therapist) should be understood as being whole, self-referential and autopoietic, among other elements (Becvar & Becvar, 2000). The wholeness of a system means that it is self-referential: The observer who describes the system also becomes part of the system since his or her acts of observing helps to construct the system (Fourie, 1994).

Any observer of a system therefore has to include himself or herself as part of that which he or she is explaining. This view of the role of the observer is different from a first-order cybernetic view where an observer is seen to be isolated from the subject in question, and thus is seen to be describing an individual or family "out there" (see Figure 3.1 versus Figure 3.2). A first-order cybernetic view then closely corresponds to positivistic views of an independent, discoverable reality (Becvar & Becvar, 2000).

The implications of a second-order cybernetic view then hold that the idea that one individual can affect unilateral influence on another (as proposed by evidence-based approaches) is brought into question.

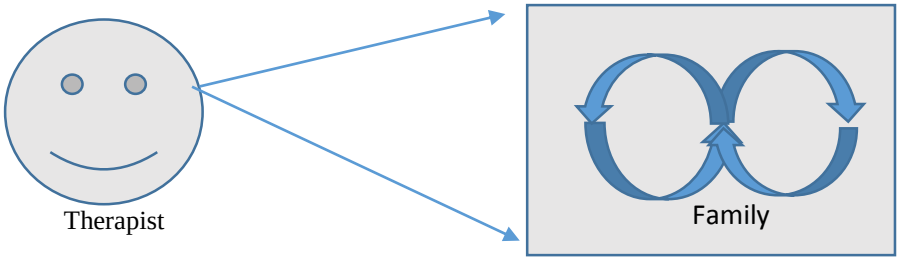

Figure 3.1 - First Order Cybernetic View of Reality

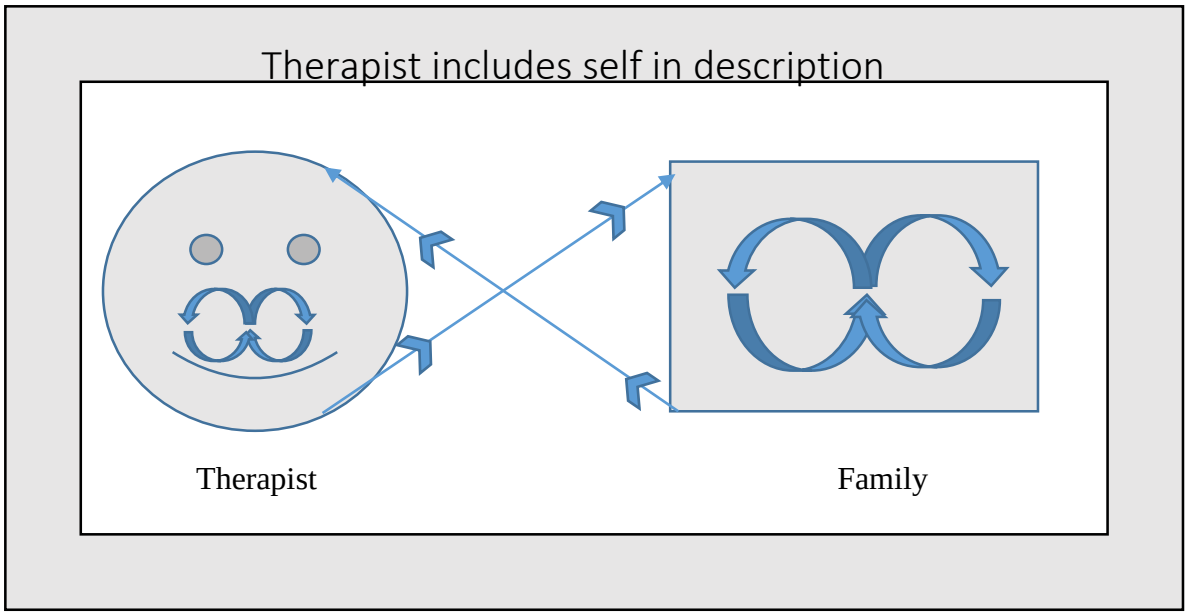

Figure 3.2 - Second Order Cybernetic View of Reality

Furthermore, the simultaneity of interactions that exist in whole systems also propose that a change process is both the cause and the effect of a client's reframed understanding of his or her problem, and that this change process feeds off the simultaneity of interaction between client and therapist. In other words, the client's reframed understanding of the problem is both caused by and causes the therapist's reframed understanding of that problem, and vice versa. This is because client and therapist are engaged in an (inter)-active process to construct the reframed understanding.

When considering the latter, and if one accepts that a therapeutic system functions as a whole system (Fourie, 1994; Lifschitz & Fourie, 1990), then simplified and reductionistic explanations of the therapeutic relationship is nonsensical from an eco-systemic worldview. Such a worldview not only challenges the notions of a unilaterally influenced psychotherapeutic relationship such as that proposed in certain evidence based and common factors models (e.g. CDOI), but also calls for the development of therapeutic models that are

more sensitive to the local relational context that serve to construct new ways of viewing the therapeutic problem.

As Efran et al. (1990) comment:

> *[Reductionistic] explanations attempt to condense and encapsulate still larger living patterns. In the mental health field, such condensations erroneously amplify the determinative importance of particular incidents over everyday drift. They yield a false picture. In life as it is lived, all successive moments "count" – not just the special few that are embroidered into our narrative tapestry* (p. 92).

Furthermore, Kugelmass (1987) argues that the labelling of clients as deviants suffering from diseases (as is often the case in psychotherapy through the act of diagnosis) should rather be substituted by descriptions that seek to view the problem behaviour in its proper ecological context.

As an example, Du Plessis and Strydom (1999), Rafalovich (2005) and Reid (1996) observed that ADHD childrens' impairments in attention and behaviour often manifest only in some situations (usually school). On the contrary, however, when such children are immersed in a stimulating activity, they are virtually undistinguishable from their undiagnosed peers. One can see the importance of local context then, since the deviant behaviour acts as a signal of "discordance" in the system in which it is rooted (Kugelmass, 1987, p. 19).

3.4 SYMPTOMS AS FUNCTIONS OF STABILITY

Eco-systemic theorists (e.g. Haley, 1963; Keeney, 1979; Tomm & Sanders, 1983; Watzlawick, Bavelas & Jackson, 1967) have paid much attention to the concept of symptoms as communicative signals of the nature of interpersonal relationship systems such as the family

or community. Keeney (1979) conceptualises symptomatic expression as *relationship metaphors*, a term that emphasises the communicative value of symptoms as compacted hints of what is going on in a relationship. Furthermore, Haley (1963) showed convincingly, in numerous of his texts, how symptomatic and deviant behaviours are strategic in nature.

Said differently, Hayley (1963) purports that symptomatic behaviours are *tactics in human relationships* because these behaviours serve a specific function in the interpersonal system in which it is embedded (Haley, 1963; Watzlawick et al., 1967). In simple terms, symptoms can be thought of as "a way of dealing with, perhaps disarming, another person" (Haley, 1963, p. 5).

The eco-systemic conceptualisation of symptoms that hold strategic and communicative value implies that symptomatic behaviour is often a stabilising force in a relationship state and therefore supports a frequently rigid stable relationship state. Bradford Keeney, in fact, observed how treating a client's complaints without addressing their problematic relationship dynamics, often results in "a transfer of symptomatic expression to another site [in the system]" (Keeney, 1979, p. 120). To make matters worse, Tomm and Sanders (1983) maintain that the use of diagnostic labelling (i.e. diagnosing the *'identified patient'* (IP)) actually threatens to entrench the 'unhealthy' relational patterns, so much so that the IP becomes fixed in his or her role as the 'sickly one' and thus the usual one to express psychological symptoms.

Due to its power to direct perceptions of, and interactional patterns towards, a diagnosed individual, diagnostic labelling may have the effect of restricting alternative ('more healthy') behaviours in the IP (Tomm & Sanders, 1983). Efran et al. (1990) sum up the unintended perils of diagnostic labels: "…in their quest to be precise – to pin problems down in objective, concrete terms – people are labeled, problems are named, and flexibility is lost" (p. 89).

Applying the latter thoughts to evidence-based approaches, one can readily see how the quest to promote the use of specific therapeutic techniques for specific 'disorders' can lead to rigid understandings of a client's problem and may hence be restrictive to our creativity in constructing new paths to solutions. To state it differently, by fixating on evidence-based treatments for specific disorders a specific pattern of relating in the therapeutic context is reinforced that may limit alternative ways of framing the problem and restrict alternative ways of relating in cases where this may be beneficial. It would seem then that the power of therapeutic actions (including acts of diagnosing) to 'disable' emanates from the communicative value they serve to promote very narrow understandings of psychiatric problems and their possible solutions.

3.5 THE ROLE OF LANGUAGE IN CONSTRUCTING REALITY

The value of recognising the communicative value of conceptualisations of clients' problems and therapeutic actions that spring from such understandings, can best be appreciated when considering the recent shift towards acknowledging the constructive power of language. By shifting their focus to language, social constructionists recognised the important role of language in shaping social reality (Brown & Augusta-Scott, 2007; Fourie, 1994).

More specifically, social constructionism postulates that reality is constructed through a social process characterised by mutual agreement between people on the nature of reality, whereby shared meanings, beliefs and values are attained (Brown & Augusta Scott, 2007; Young & Collin, 2004). To achieve this social 'contract', Sey (2006) suggests that social agents depend on linguistic structure to produce the resulting reality constructions. Language and the strategic use thereof is the powerful force that shapes social realities and it is through language that these realities are transmitted from one generation to the next through a system of shared

meanings, known as culture. It is this idea of the communal production of social reality that forms the foundation of social constructionist epistemology: That different realities are created by means of a social process of shared meanings that then also implies the probability of multiple and contextually-informed realities.

Jacques Derrida's works (see Derrida, 1973; Derrida, 1982) for instance draw attention to the importance of questioning western society's assumptions on various levels (ethics, politics, social and human sciences, etc.) by unravelling the texts that serve to uphold the order of the day. He asserts, among other things, that assumptions are carried, sometimes imperceptibly, by the vehicle of language to construct certain accepted 'truths', that is the status quo to the detriment of other equally valid 'truths' (Montero, 1997). Derrida's work serves to expose this insidious power of language to promote certain conceptions above others through deconstructive analysis.

Of particular interest is Derrida's focus on binary oppositions, that he believes frequently remain unarticulated in scholarly language, especially in social sciences, and may assist in the uncritical promotion of certain views over others. For the social sciences, among other sciences, to overcome this deficiency, Derrida is of the opinion that scientific texts need to be deconstructed to expose the value-laden assumptions that are embroiled in their narratives through unspoken binary oppositions (Montero, 1997). The articulation of binary oppositions (such as normal versus crazy or competent versus incompetent) then allows for the speakers to consider how different conceptualisations of their experiences may expose other, previously concealed meanings. In the practice of psychotherapy, Derrida's ideas on the deconstruction of meaning have important and powerful implications.

As an example, Terre Blanche, Durrheim and Kelly (2006) highlight the subtle power of implicit binary oppositions, where one part of the binary opposition is explicitly stated and

the other part is implied but silenced. This practice can have immense directive power in the hands of a biased or ignorant psychotherapist. Such silencing is illustrated when a psychotherapist says to a client that she is pleased to see that his complaining has subsided and that it is a sure sign that his depression is lifting. The implicit message is that his complaints are unpleasant and a sign of dysfunction, signalling the possible functioning of the 'no news is good news' discourse.

Such binary oppositions can have the effect of setting boundaries in the therapeutic dialogue as to what is acceptable versus unacceptable ways of conceptualising the client's problem. By uncritically upholding a binary opposition the psychotherapist, often blissfully unaware, may appeal to her audience (i.e. the client) to align himself or herself to a particular side of the opposition (usually the side advocated in the psychotherapist's text) and therefore have immense power in creating a particular worldview of the problem and closing the possibilities for alternative worldviews of the problem (Terre Blanche et al., 2006).

In the arena of family therapy this shift in thinking about the power of language to construct reality is illustrated in Gregory Bateson's ideas. Bateson, who echoes Foucault's (1980) idea that power is a social construction, was one of the first to apply these thoughts in the treatment of families (Cecchin, 1992). This power, that families were said to battle for, was no longer seen as an entity to possess, but rather became a creation of people relating to one another in a specific context and who act as if it exists.

For example, the power an abusive husband holds over his wife is partly a result of her submissiveness towards him, whereas her submissiveness is partly a result of his dominance over her. The different roles each plays cannot be separated since these form the basis of the mutual agreement between them regarding the nature of their relationship. Both play their respective roles in constructing the husband's power through what Maturana (1975) calls

structural coupling. This means that individuals couple their behaviour to fit with the family environment so that the relationship of one segment of the family provides a context for the behaviour of another member. The sum of the coupled behaviour in turn forms the family environment. This means that no individual member's behaviour can be seen as being isolated from the family environment and the family environment cannot remain what it is without the said individual's coupled behaviour.

As can be seen thus far, social constructionists reject the idea of an underlying structure in any phenomenon being studied (Andersen, 1992; Brown & Augusta-Scott, 2007; Cecchin, 1992; Fourie, 1994; Hoffman, 1992). For instance, this view would suggest that any structured patterns observed in a family are not inherent qualities of that family, but rather constructed through social negotiation via the medium of language.

The order and meanings we observe when we look at a family interacting, is in fact the result of an interactional process whereby order and meanings are constructed (Fourie, 1994) and that is likely to change over time. Said differently, because our observations are informed by the language we use to describe them, these observations will always reflect political and ideological power relations among those who observe and those who are being observed (Hoffman, 1992). Also, the meanings attached to these observations may change relative to changes in society.

In a similar vein, Efran and Clarfield (1992) and Brown and Augusta-Scott (2007) argue that, from a social constructionist viewpoint, it is probable that no-one can ever claim to observe a truly objective reality. On the other hand, these authors insist that each person is entitled to a preferred way to view reality, and that such a reality should never be represented as *the truth*, but rather one of many truths.

In her work, Frugerri (1992) emphasises the self-referential nature of observing systems, whereby knowledge of a subject relies heavily on the observer's descriptions and choice of language, thus making the product of observation naturally subjective and value-laden. The observer therefore constructs and joins the system being observed, purely through the act of observing (Fourie, 1994). This act of observing then continuously changes the observer's relationship to the system in an interactional, circular process whereby each subsequent act of observation creates new information about the system (Fourie, 1994; Frugerri, 1992). By applying the latter discussion to psychotherapy, one can see how important it is for a therapist to attend to his or her relationship with a client in a self-referential fashion.

Andersen's (1992) words on self-referential observations hold particular value in the field of psychotherapy, since he states that:

> *... we do not relate to life 'itself' but to our understanding of it ... [and furthermore] we strongly participate in creating our understanding of life... [and consequently] there are as many versions of a situation as there are persons to understand it* (p. 61).

These words imply that, from a social constructionist epistemology, a psychotherapist can no longer be seen as separate from his or her client or seen to be objective with regard to the techniques he or she employs. This is because the therapist as a self-system possesses the quality of organisational closure (Becvar & Becvar, 2000).

This means that the therapist cannot observe the client without referring to his or her own subjective experiences of that client, and thus the therapist cannot make treatment decisions without taking into account his or her subjective experiences of the client. The concept of evidence based treatments that are chosen objectively by a therapist, based on its

proven efficacy, therefore becomes a seriously problematic concept from a social constructionist epistemology.

On the other hand, much criticism has been aimed at social constructionists' rejection of true objectivity. Critics often argue that social constructionism amounts to solipsism, as each individual is allowed to relate to his or her own version of reality (Efran & Clarfield, 1992). The danger of this line of thinking is that since there is no objective truth, there is no standard against which to evaluate the validity of any assumptions about reality. In its defence, however, it should be noted that social constructionism assumes that any individual's assumptions about reality is embedded in a social context (Brown & Augusta-Scott, 2007; Cecchin, 1992). This implies that our assumptions are kept in check by the broader social narratives that set the boundaries of our assumptions of reality (Efran & Clarfield, 1992).

Cecchin (1992) further argues that in addition to facilitating the construction of meanings to help people make sense of reality, social interaction also becomes a way for a person to define the self in a relationship with the social and physical environment. People's social exchanges (and by extension, therapeutic exchanges), therefore also represent attempts to construct realities that hold with it the limits and possibilities they face as individuals related to that environment.

3.6 LANGUAGE: THE DOUBLE EDGED SWORD

In the foregoing discussion it was argued that the language an individual uses to describe his or her experiences is pivotal in setting the boundaries for his or her behaviour. From this line of arguing it can further be said that language then forms the basis for the creation and resolution of psychological problems in the form of problem- and solution narratives (Brown

& Augusta-Scott, 2007; Efran et al., 1990; Payne, 2006; White, 2011). Anderson et al. (1986) explains the formation of an ecology of ideas around:

> *…the shared, cognitive, and linguistic discourse through which we derive meaning, and out of which we create the realities of coordinated action systems. Through language individuals interact with and coordinate behaviour with others in a variety of ways. This can even be ways that are thought of as problems* (p. 6).

Therefore, the quality of an individual's behaviour (in terms of deviance and normality) is determined by the way that behaviour is languaged as deviant or problematic (Fourie, 1994; Terre Blanche, 1998). The observer attributes value (normal or abnormal) to the said behaviour that he or she derives from his or her identification with a specific cultural (or subcultural) value system.

For instance, any person's fear response is merely a bodily reaction to objects or situations. The body responds to a stimulus without evaluating the appropriateness or intensity of that response. It is the client's or therapist's mind that determines (in the form of cognitive evaluation and comparison to a cultural standard) the appropriateness and intensity of the behaviour and categorises it as either deviant or normal. Efran et al. (1990) argue that "fears only seem disproportionate to danger when they belong to another person or are evaluated from another perspective" (p. 91).

Therefore, a person enrols the position of phobic when his or her behaviour is assessed to be outside the limits of normality from an external perspective. Through this evaluation against an external value system it is negotiated that the person has a disorder that leads to the formation of a 'coordinated action system' that directs behaviour towards the identified problem. Anderson et al. (1986) terms this a 'problem-determined system', since the

organisation of the system, including IP's function in it, is now being determined by the claim that there is a problem that needs attention.

An example of a problem-determined system is when a couple (as an organised system) concludes that their child's clingy behaviour needs to be addressed. Since the child's clinginess can be viewed as a normal attachment to the parent, it is likely to be framed as problematic only once it leads to a disruption of the parents' harmonious inter-relations, especially if one or both start(s) to experience frustration as a result of the behaviour. This usually occurs when one parent, for example the father begins to evaluate the child's behaviour against the 'normal' expectation of how children should behave: for example "children should play outside".

The mother may disagree, and defend the child's need for nurturance. Strain in the marital relationship is likely to arise on how to manage the child's "clinginess". This may lead to conflict and a rise in the child's anxiety levels. Before they wipe their eyes, the parents are faced with a problem that continues to exacerbate, until they decided that "our child is abnormal and needs to see a therapist".

Thus the initial description of the child's behaviour as being 'clingy' sets in motion a distinct pattern of organisation in the family system to address the child's problematic attachment patterns. The identified problem (framed as residing in the child) determines the workings of the system (Anderson et al., 1986). Alternatively, if the father frames his frustration as emanating from a lack of affection from his wife, instead of from an interfering child, the problem-system would likely direct the family to couples therapy instead of play therapy for the child.

Since most social problems are a product of the language used to describe them, there is no sound agreement on what aspects of language account for its power to construct social reality. Some critical approaches (e.g. Foucaultian theories) highlight the power of actual words

and phrases to construct the power that some group (e.g. doctors and psychologists) hold over another group (e.g. psychiatric patients). On the other hand, Searle (as cited in Terre Blanche, 1998) is of the opinion that language derives its constructive power from "s*peech acts"* (p. 144).

According to Terre Blanche (1998) the process involved in the performance of a conversation is more important than the contents (i.e. spoken words) of that conversation. For meaning and power to exist in words, there needs to be meaningful interaction between a 'speaker' and a 'hearer'. The speaker needs to say something powerful or overpowering and the hearer needs to understand what is said as being powerful and overpowering in order for meaningful power to come into being.

Apter (as cited in Kugelmass, 1987) demonstrates how the interaction between the individual and social environment leads to the identification of a deviant person, where the deviant behaviour is created via:

> *... a disparity between an individual's abilities and the demands and expectations of the environment – a "failure to match" between the child and the system. It is not the child alone or the environment alone that causes emotional disturbance. Rather it is the interaction between them that creates a discordance and disrupts the system* (p. 19).

When viewed from an ecological perspective, language is accepted to be the vehicle for generating and resolving problems (Brown & Augusta-Scott, 2007; Fourie, 1994). However, by saying that psychological problems are constructed through language, it is not meant that these problem behaviours do not exist. Instead it is suggested that the language people use to describe behaviours can lead to the exacerbation of those behaviours as problems, or to the

resolution of those behaviours by adopting descriptions that allow for more flexibility to adopt alternative behaviours (Efran et al., 1990).

Furthermore, the conceptualisation of clients' problems as being embedded in a narrative framework does not imply that clients' problems are not real (Efran & Clarfield, 1992). In fact, Cecchin (1992) argues that since people utilise narratives to negotiate the limits for their personal agency, the use of very restrictive language to make sense of an experience can lead to that individual experiencing very real problems.

Checchin (1992) further suggests, that it is through engaging in social interactions that individuals are afforded the opportunity to extend their definitions of themselves as well as the problems they face. It is through this extension of their narratives of the self and their problems that individuals become aware of new possibilities to expand their personal freedom. Linking to this idea, Andersen (1992) postulates that psychotherapeutic conversation can be defined as an individual's search for new descriptions and definitions of the self with which he or she would be most comfortable.

3.7 NARRATIVE CONCEPTUALISATIONS OF PSYCHOTHERAPY

Given that psychological problems are defined, from a social constructionist viewpoint, as the product of overly rigid problem narratives that restrict an individual's ability to recognise clear paths to its solution, it is accepted that the resolution of psychological problems can also be achieved through the medium of language. The therapist could thus seek to utilise discrepancies in meaning that exist between his or her own and client's descriptions of reality in order to negotiate a new problem narrative that is less restrictive in its potential paths to solutions (Brown & Augusta-Scott, 2007; Cecchin, 1992; Fourie, 1994; Payne, 2006; White, 2011).

For instance, consider the dilemma of a man confronted with the conflict between his wish to get divorced and his religious conviction that prohibits the dissolution of marriage. Due to his religious convictions, he finds himself trapped in a loveless and frustrating marriage. His context is thus a breeding ground for a whole list of psychological problems including depression, anxiety, sexual dysfunction, somatic complaints, infidelity, aggression, etcetera.

Given this life contradiction, the man is faced with the following conundrum: "do I stay true to my beliefs and be miserable for the rest of my life, or do I forsake my beliefs in favour of happiness?" Obviously, one can sense that neither of the choices he has languaged for himself would resolve the issue of his unhappiness. The social constructionist aim of intervention in such a case seeks to expand the problem definition so that more options become available in the search for a solution that accommodates both of the client's contradictory preferences.

By reflecting on the different ways that the client and therapist define various aspects of the problem, a negotiation takes place where both start to redefine their personal view of the problem based on feedback by the other. Over time and through reflecting on their differences, a shared narrative starts to develop through a negotiation between client and therapist on their different viewpoints of the problem (Andersen, 1992; Brown & Augusta-Scott, 2007; Cecchin, 1992; Frugerri, 1992; Payne, 2006). The man's dilemma discussed above, may be resolved when his definition of what it means to be religious is expanded to allow for the possibility of divorce. Alternatively, his definition of marriage might expand, making it possible for him to see his marriage in a different (perhaps even more satisfying) light.

If the process of change, as conceptualised from a social constructionist viewpoint, is to utilise discourses to reframe personal narratives and extend the limitations placed on a client's agency, it could be hypothesised that all 'effective' models of psychotherapy are based

on a similar process. In fact, as Fourie (2012) points out, behaviour change across divergent approaches relies on two processes:

> *…the development in conversation of a shared understanding of the problem…which is somewhat different from the client's original conception…followed by action which is considered to be coherent with…the developed understanding* (p. 131).

As seen from the foregoing argument, relying on reductionist conceptualisations of psychotherapy (as proposed by evidence-based approaches) would seriously restrict the creativity needed for such a co-constructive process. Also, it is has been argued that being aware of lists of common factors and their statistical values is not enough. Without a guiding model of a change process that provides opportunity for a therapist to incorporate common factors into a coherent yet flexible approach, such a creative co-constructive approach may be difficult to achieve.

3.8 SOCIAL DISCOURSES: OUR MAPS TO FREEDOM OR STAGNATION

It is accepted here, as suggested by Fourie (2012) that the common factors and specific techniques have equally important roles to play in effective psychotherapy, but that the magnitude of those roles would differ from client to client. An effective model in this regard would allow the therapist to reflexively introduce common factors relevant to the psychotherapy process into the interactive space between himself or herself and the client for reflection of the meaning of said factors. Also the model should allow the therapist to reflexively respond to factors that the client spontaneously or purposely introduce for discussion.

Such a model would then allow for a creative interaction between client and therapist to negotiate on the impact of various factors on his or her understanding of the problem and by so doing co-construct a shared worldview of the problem that allows the client more personal agency and that extends the limitations placed on their personal freedom by the previous meanings he or she attached to his or her problem.

In other words, just as a client's constructed realities (as mediated by the language and discourses available to them) have the potential effect of defining himself or herself as 'deviant', 'victim' or 'outcast', a different reality construction (as mediated by the language and discourses provided in the context of psychotherapy) could have the effect of helping a client define himself or herself in new ways that lead to obvious and reachable solutions to his or her problems. In such a model, interaction (both verbal and non-verbal) between therapist and client is what leads to the introduction of certain discourses by either client or therapist. These discourses may direct the therapeutic narrative, but the client and/or therapist may also redirect the therapeutic narrative by introducing new or different discourses.

Since discourses have the power to direct our understandings of ourselves and others, our place in the world and thus also our behaviour (Van Zyl, 2009), they may be accurately described by using the metaphor of a map. Maps in themselves are harmless pieces of paper with little power of their own. However, when used by an individual, maps may gain certain powers that can be thought of as benevolent or devious.

Take for example, a woman who is lost and uses a map to find her way again, probably thinks to herself 'Thank you map!' On the other hand, a man who automatically tunes his GPS to take him home, may later curse his map for leading him straight into a traffic jam. If he had been more thoughtful of his interaction with the map he may have detected earlier that it was leading him on a route that spells trouble and altered his direction. In a similar manner, social

discourses, when followed uncritically, may be very devious in directing our thoughts and behaviours. This is especially true in the context of psychotherapy, where navigating social discourses forms the bulk of the therapeutic process.

Therapeutic common factors, including diagnostic labels, therapeutic techniques, theoretical models, etcetera. are rich sources of social discourses that may have an insidious way of directing the client's personal narrative as well as the therapeutic narrative (Van Zyl, 2009). It is very important, therefore that the therapist remains reflexive when discourses are introduced so as to avoid the reification of dominant and/or debilitating discourses in the therapy process.

For instance, a man diagnosed with an anxiety disorder is faced with a multitude of discourses surrounding his diagnosis. First, gender discourses accompany the fact that he is a man and advocate that men should exude rationality, courage, masculinity, fearlessness and the like. Second, medical discourses, which accompany anxiety disorders, suggest that phobias are exaggerated, irrational and unfounded fears. When utilising these discourses in framing his experience of being diagnosed as a 'phobic', he can easily define himself as a 'wimp', since he is excessively fearful, overreacts when faced with the object he fears and, in addition, his actions seem to be irrational and illogical.

Therefore, the discourses, when organised in this way, present the man with an emotional contradiction, in that his fears cannot be reconciled with his masculinity, which would likely heighten his distress. However, by reorganising these discourses, the meanings he attaches to his 'disordered' behaviour can be framed in a more useful way, as when he might recognise that he is faced with most men's biggest fear, namely being emasculated by a 'mental disorder', and might rise to face that fear head-on. This reframed explanation of his experience serves to expand the limitations placed on his masculinity by the former framing and

consequently resolves the emotional contradiction that existed before. He can now define himself as a very brave man who stood up to and conquered the fear of being emasculated by an anxiety disorder.

Notice that the discourses in the example above can be seen as being representative of various therapeutic factors. The gender discourse may be representative of a client factor (e.g. client fears or weaknesses), whereas the medical discourse may be representative of a therapeutic factor (e.g. model factors such as diagnosis and assessment). Also, the specific formulation of the problem from the therapist's worldview and techniques such as positive connotation may represent therapist- and technique- factors respectively. Common- and specific factors then are conceptualised as rich sources of discourses and metaphors that can be reflexively employed in the therapeutic interaction to assist with the co-construction of a new understanding of the client's problem.

3.9 IDENTITY AND LANGUAGE

Given the role of language (in this case, specifically the language surrounding psychological problems) in constructing interpersonal realities, it follows that language also holds important implications for the definition of self of an individual. When referring to the notion of self, social constructionists reject the modernist tendency to define the *self* as a structure-determined inner reality, consisting of emotions, cognitions, etcetera, that assumes a fairly rigid form over the lifespan.

Rather, according to Hoffman (1992), the self is viewed as a continually evolving entity that waxes and wanes over time, much like a "stretch of moving history" (p. 10). She maintains that any person's experience of himself or herself is imbedded in a relational field where changes in others' reactions to him or her affect the way he or she experiences the 'self', and

vice versa. Therefore, the 'self' is described in terms of circular interactions that cause it to evolve and change shape over time.

Andersen (1992) also highlights the interactional nature of the concept of self and maintains that by using language, people express and construct their being by defining themselves in discussions with themselves and others. Thus, any interactions or events are related to one's construction of the self through the language that is used to describe oneself in relation to such events. Andersen (1992) goes so far as to say that "talking with oneself and/or others is a way of defining oneself. In this sense the language we use makes us who we are in the moment we use it" (p. 64).

Related to the concept of self as a continuously evolving process, the idea of normal human development also takes a different meaning when viewed from a constructionist viewpoint. Hoffman (1992) posits that the traditional psychological notion that normal human development occurs in developmental stages is unwarranted in that there is great variability regarding human development and to single out one 'optimal' route is to step into the same trap of a singular truth (Payne, 2006; White, 2011).

When applied to the field of psychotherapy, the rejection of the idea of a singular optimal developmental route would extend to the rejection of a singular optimal therapeutic intervention. Moreover, since language becomes the force that defines individuals' identities, one can argue that a specific therapeutic model may at most provide the therapist and client with a specific set of concepts, metaphors and rituals to assist with constructing an alternative, problem free identity.

Given the social constructionist view of the self, and the multitude of developmental pathways open to people, it seems to open new avenues for thinking about therapeutic effects. In fact, it brings into question the whole assumption that specific techniques and models may

hold certain desired therapeutic effects over others. It calls for shifting focus away from the model or technique applied to *how* this model or technique is applied by this specific therapist in interaction with this specific client in this specific context. The value of models and techniques then is still retained, but responsibility for change shifts to the therapist (and client) in the way they use the concepts, metaphors and discourses contained in the model or technique to construct a new view of the problem that make satisfactory solutions more apparent.

3.10 MODELS OF PSYCHOTHERAPY: METAPHORS FOR CHANGE

The common factors approach suggests more/less equality among psychotherapeutic models and approaches, in that their usefulness is based on the psychotherapist's evaluation of what each might offer him or her in the specific psychotherapeutic situation. Of course, given the importance of language and narratives in social constructionist epistemology, it is assumed that, at a fundamental level, any psychotherapeutic model represents a frame for viewing the client's difficulties (Becvar & Becvar, 2000). As reality constructs, different therapeutic models provide different systems of narratives, discourses and metaphors that allow for the negotiation of a larger frame of reference in which the client's problematic (i.e. competing & mutually exclusive) narratives/wishes/morals/drives etcetera can be resolved.

The psychodynamic school of therapy, for example, produced various models of personality, human behaviour and its pathologies as well as means of remedying abnormalities in behaviour and character (Viljoen, 2003b). In this sense the Freudian conceptualisation of personality as a steam engine can be seen as providing a framework for organising the therapist's and client's understanding and observations of otherwise abstract and intangible behavioural percepts.

For example, when subjected to discourse analysis, the concepts of unconscious drives and motives suggest that the person's behaviour stems from an unknown 'power source' that pushes the client's behaviour and experiences in a particular direction, that is a direction aimed at achieving specific underlying (not-yet-known) goals. These apparently simple terms have numerous implications for the construction of the agency of the client and therapist. First, a reality is constructed wherein the client is framed in a passive subject position, and is subjected to impositions from an unknown (ego dystonic) source. Second, the client is framed as being dependent on this ego dystonic source for his vitality, immediately placing him in debt of the unconscious. Also, a schism is constructed in the identity of the client so that two sets of motives and drives are probable, the conscious (known) and the unconscious (not-yet-known), yet the vitality for accomplishing these motives emanates from one source only (i.e. the unconscious).

This conflict of interest, coupled with a limited energy resource and the obscurity of one agent (i.e. the unconscious), lays the grounds for an inequitable power struggle, one that the 'conscious' client is not even aware of. Note also that the paradoxical phrasing of the 'conscious yet unaware' client is utilised to illustrate how the 'conscious' lacks true personal agency precisely because it is unaware of its lack of personal agency. Thus any control that the conscious person believes he or she has, is pseudo control, as it is exactly this 'control' that maintains the obscurity and power of the unconscious.

It is then clear how these psychodynamic concepts, as described above, construct the client as someone with little agency and personal knowledge apart from that allowed by the unconscious. Thus the dominant narrative in such a model of human behaviour leans toward the image of the conscious person caught in a ruse to believe he is navigating his path, while all along he is the vehicle driven by an inconspicuous driver (i.e. the unconscious) with its own motives on which direction to take.

The latter way of languaging the psychodynamic construction of the client then evokes certain discursive questions: What contributes to the power imbalance between the client and his unconscious? What or who allows the unconscious to have unilateral control of the client's source of vitality? Finally, given that the unconscious is predominantly out of sight and out of conscious mind, what contributes to and maintains this schism? The model as a therapeutic factor provides the therapist and client with the discourses and metaphors to critically entertain and reflect on such issues as mentioned. In this way the specific model (with associated discourses and metaphors) impacts on the co-evolving and mutually constructed new meaning of the problem.

The pursuit to answer the above-mentioned questions, at least from a social constructionist perspective, is what forms the basis of a therapist's understanding of the intra-psychic power relations of the client. Note that a simple concept can serve to satisfactorily answer all of the above three questions: that is knowledge (or a lack of it) is what contributes to the power imbalance between the conscious and unconscious structures of the personality. The unconscious has access to all, the conscious has access only to what is deemed as conscious knowledge. Whatever the conscious knows of the unconscious depends on the generosity of the unconscious. Since the unconscious 'knows', it is in a position to control (i.e. has power over the needs, drives and the vitality to pursue these).

The schism between the conscious and unconscious is also a product of knowledge (or the lack thereof), much like a captain who is unable to address mutiny when unaware of it, so the conscious cannot address the schism if unaware of it.

From a social constructionist perspective then, it can be said that numerous social discourses operate in the psychodynamic construction of the personality: Knowledge is power, internal origins of power, etcetera. These discourses then inform the client's understanding of

his own personality functioning and the dynamics of his relationship with his unconscious. In other words, the client gains knowledge of the existence of the unconscious, its power and his own lack of power. Using the psychodynamic model as a metaphor, one might say that therapeutic talk engages the client in the process of resolving unconscious (not-yet-known) conflicts by gaining insight and acceptance of the nature of the self and the power of the unconscious to direct behaviour.

Contra-intuitively, the client's growing knowledge of his lack of knowledge and power in relation to the unconscious actually allows the therapist and client to construct a worldview of the problem that provides the client with options, and hence the agency, to redress this power imbalance. Likewise, a captain's awareness of mutiny gives him opportunity to deal with the mutineers, so the insight of the client provides opportunities to exercise more control by changing his relationship with the unconscious. According to the psychodynamic construction then, knowledge (awareness) equals power, and a clear implication for the agency of both therapist and client is the pursuit of awareness in the form of insight.

It is argued here that a therapeutic model, as a therapeutic factor, acts as a source of discourses that can be activated in the therapeutic process to inform the therapeutic narrative. The responsible utilisation of a specific therapeutic model requires the therapist to critically and reflexively invoke, or respond to, discourses and metaphors that are activated in the interactive space. For example, the hero discourse, when activated with the help of a therapeutic model, may prompt a client to construct her identity by thinking in terms of the hero/villain contingency regarding the self-definition. It calls on the client to align herself in relation to either, and both, of the poles of this hero/villain contingency.

Other related discourses, in turn, when activated, may influence this alignment of the client. For example, the individuality discourse versus the 'flock' discourse may combine with

a rebellion discourse versus a conformity discourse to construct the client's worldview of the problem and her relation to it in various ways, so as to inform possible paths to action. By adopting a critical and reflexive stance, the therapist may question, in the client's presence, whether the resulting narrative construction of the self and the problem is positive or negative for her, thereby implicitly reinforcing the idea that such narrative constructions are not necessarily fixed and inflexible.

3.11 THE CRITICAL NATURE OF SOCIAL CONSTRUCTIONISM

In explaining the critical stance that social constructionism takes, Young and Collin (2004) contend that "most social constructionisms overtly challenge orthodox, positivist assumptions" (p. 377) and also cite Gergen saying that "social constructionism asks a new set of questions – often evaluative, political, and pragmatic – regarding the choices one makes" (p. 377).

When adopting such a critical stance it is important to consider the important distinction that Anderson and Goolishian (1992) draw between *local meanings and dialogue* and *broadly held cultural sensibilities*, the former referring to "the language, the meaning, and the understanding developed between persons in dialogue…" (p. 33). Anderson and Goolishian (1992) recognise the importance of local meanings to be situated in the fact that "there is a range of experiences and a way of knowing these experiences that is sufficiently different from 'knower' to 'knower'…" (p. 33).

It therefore becomes apparent that, from a social constructionist perspective, the effects of a specific psychotherapeutic interaction cannot be abstracted from the relational context in which the new meaning that informs the problem as well as the resulting behaviour change is co-constructed. Taking these points into consideration, it becomes a wasteful exercise to debate

the superiority of any given technique for any given diagnosis, as the local meanings and dialogue surrounding technique, diagnostic label and any other factor in psychotherapy are highly likely to differ considerably from one therapeutic process to another, even where the technique and diagnostic label remains constant.

In a social constructionist model of psychotherapy, technique and diagnostic labelling do not form *the* context for psychotherapy, but can rather be seen as being part of a range of other factors that all contribute to the context of change in the psychotherapy process. The degree of importance each of these factors holds in the overall process, depends on the co-evolving narrative that develops continually between the client and therapist as each contribute to it by emphasising factors and reflecting on its role in the evolving narrative.

For instance, a client diagnosed with MDD may change his perspective of MDD from a label that signals underlying abnormal brain processes to one that signals a discord in his relationship with his introjected self-object. Utilising this co-constructed new understanding of MDD leaves more opportunity for the client to exercise personal agency upon the problem by addressing the relational difficulty with himself. The client and therapist may construct the narrative as follows: That the client has 'unconsciously' forsaken an alliance with 'the self' in order to build an alliance with others. This neglected relationship with the self then caused unspoken resentment between the client and his introjected self-object, leading to heightened levels of self-loathing, hopelessness and depressed mood.

On a wider systemic level, the real-time effects of the ongoing new construction of meaning forms another factor that may be introduced into the therapeutic conversation as a matter that shapes the continually evolving narrative. In other words, the ways in which the client's social world organises itself in relation to the client's newly evolving understanding of

the problem (i.e. effects of therapy) is fed back into the therapeutic system in a way to further impact on the therapeutic process of interaction.

Feedback, as a therapeutic factor, is extended beyond the client's experience of difference and also incorporates others' reactions (including the therapist's reactions) to differences in the client. Feedback, from a social constructionist approach to psychotherapy, is not linear (from client to therapist), but circular, meaning that both therapist and client receive simultaneous feedback on their effects on each other as well as their effects on the wider social system of which the client forms part. This information then shapes further co-evolution of the local meaning attached to the problem.

The client discussed above, may start to address the forsaken alliance with the introjected self-object by verbalising the unspoken resentments and developing new trust and empathy with the introjected self-object. The therapist's role is crucial in that he or she tracks this narrative by providing reflection and feedback given his or her *expert knowledge* on mending broken relationships. This feedback may strengthen the client's sense of personal agency, but also may foster a sense of interpersonal validation and normalisation by legitimising the more empowering narrative of a broken relationship versus the narrative of intrapsychic dysfunction.

As a result, the client may start to consciously address imbalances in his alliance to the self by standing up for the self in relation to others. The therapist may utilise the factor of feedback here by enquiring about significant others' reactions to this change in the client's behaviour. The client's experience of others' reactions to his increased self-assertiveness (i.e. whether he experienced it as positive or negative) is also feedback to the therapist. The information that both the client and therapist obtained from this feedback process is useful in further refining or redirecting the evolving narrative as required.

By maintaining and fostering a critical and reflexive stance then, the psychotherapist shapes a therapeutic process that is creative rather than limiting and restricting. To achieve this, he or she needs to let go of attachments to preferred ways of explaining reality and embrace the post-modern concept of multiple realities. Such a therapist will come to appreciate that the value of a specific explanation of a specific problem is determined by the local context and dialogue rather than by universal laws.

A therapist that is appreciative of local context and dialogue will be free to question and reflect on restrictive 'one size fits all' worldviews in the search of a worldview tailored for the specific individual in his or her specific context. The therapist's major contribution to the process of psychotherapy is to transfer and foster this reflexive and critical stance in the therapeutic process and eventually to the client as he or she ventures forward independent from the therapeutic relationship (Hoffman, 1992; White, 2011).

Considering the foregoing discussion on psychotherapy as a collaborative attempt to reframe a problem in order to allow for flexibility and alternatives, it becomes clear that a social constructionist model is critical of universally imposed techniques. In search of a social constructionist model of common factors which also encapsulates critical and reflexive attitudes that are crucial to the process of therapy, it is important that users of such a model remain aware of their responsibility to appreciate it as a guiding model and not as a universal method.

As Efran et al. (1990) propose, one can get caught up in an ideological debate on complex issues of trivial importance when one takes too serious the idea that certain distinctions are so fundamental that they can yield permanent objective truths. Therefore, scientific endeavour in this view ceases to be a quest for *the* question that would yield *the* answer. Rather, the goal becomes to ask questions in such a way as to open new doors for

alternative answers to become a possibility, steering clear of those absolutes that are no better than wool over the eyes.

3.12 CONCLUSION

The post-modern paradigm had widespread effects on scientific thinking, especially in the realm of human sciences such as psychology. Social constructionism and constructivism are some of the post-modern movements that contribute to a critical reflection on the state and nature of scientific knowledge as well as questioning the scientific observer's role in constructing knowledge. This chapter focussed on outlining the various contributions of the post-modern paradigm to the field of psychotherapy with specific attention on critiques from a social constructionist epistemology.

Despite the many questions raised regarding the legitimacy of accepted psychotherapy policies and practices based on positivist assumptions, social constructionist researchers are often criticised for being critical while not offering much in the form of practical and viable inputs or solutions to the identified problems. Baring this critique in mind, the next chapter focuses on outlining a social constructionist model of therapeutic factors in an attempt to address existing shortfalls of evidence based- and common factors approaches.

CHAPTER 4

A SOCIAL CONSTRUCTIONIST MODEL OF THERAPEUTIC FACTORS

The foregoing discussion outlined elements of postmodernism as well as social constructionist and constructivist understandings that inform the process of psychotherapy. Embedded in this discussion were critiques of positivist conceptualisations of psychotherapy that tend to reduce its complexity to the performance of specific techniques to specific populations of clients, or to common factors that are relatively unintegrated and mainly quantified.

Various implications for a social constructionist model of psychotherapy based on therapeutic factors were considered. In this regard a general argument is espoused that suggests that a purely positivistic worldview, and as a result a purely empirical method, may restrict a therapist's critical self-reflexivity. It is then important for a social constructionist view to offer some constructive input to promote psychotherapists' reflexivity and encourage their acknowledgement of a multiverse of possible roles.

These inputs come in the form of a social constructionist model of therapeutic factors that discards the idea of ultimate truths, encourages reflexivity in both client and therapist and asks the therapist to embrace the idea of actively constructing therapeutic problems and their solutions together with clients. This section focuses on summarising and integrating elements of the foregoing discussion into a formal model of psychotherapy from a social constructionist perspective utilising therapeutic factors.

Within this model, the therapeutic supra-system can be defined as the overarching factor that is responsible for therapeutic outcome (or equals the sum of all the other factors)

and can thus be thought of as the *therapeutic supra-factor*. The client and therapist form the next level of factors as agent-factors who interact by reflecting on themselves as factors in the therapeutic process, reflecting on each other as factors in the therapeutic process and reflecting on all the sub-factors of the therapeutic process (including diagnostic labelling, technique, alliance, feedback, etc). This model is presented graphically in Figure 4.2.

4.1 PRE-THERAPEUTIC STAGE

In this stage, the client functions as a predominantly closed system. He or she becomes aware of a problem via feedback from the social environment. The nature of this problem is coloured by the client's worldview (i.e. informed by some or all client factors) and thus the worldview serves to form an explanatory mode for the difficulties experienced either internally or through environmental feedback. This explanatory mode serves a purpose of directing action in order to resolve the problem.

For example, consider a woman that who has had a fear of spiders for most of her life but without much interference on her daily functioning. When she suddenly starts dreaming of spiders and experiences panic when she wakes, she finds it hard to divert her attention away from the images of spiders and the anxiety associated with it. Her preoccupation may seem 'normal' at first, until friends start to give her feedback that she has lately not been herself. She may also start to notice that her work performance has decreased, that she feels constantly tired and has become dependent and needy of those close to her.

Given her worldview informed by westernised culture, she knows a bit about psychology and it all starts to fall in place: She has developed a phobia of spiders and needs to find ways to deal with her 'irrational' fear. Her explanation of the problem, however, is limited

by her personal worldview, and will continue to remain a closed system for as long as she keeps this problem to herself (see Figure 4.1).

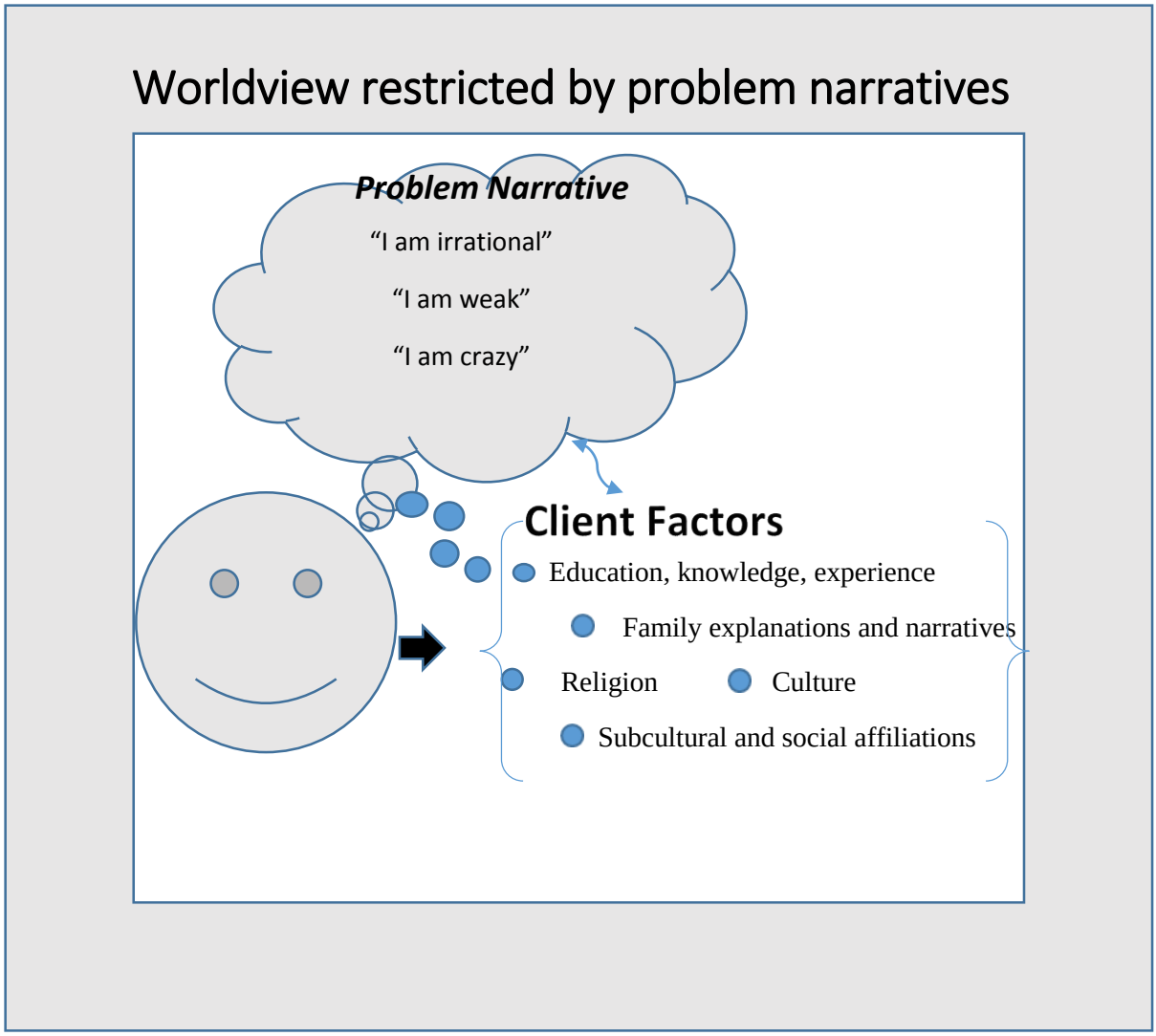

Figure 4.1 – Pre-therapeutic Stage

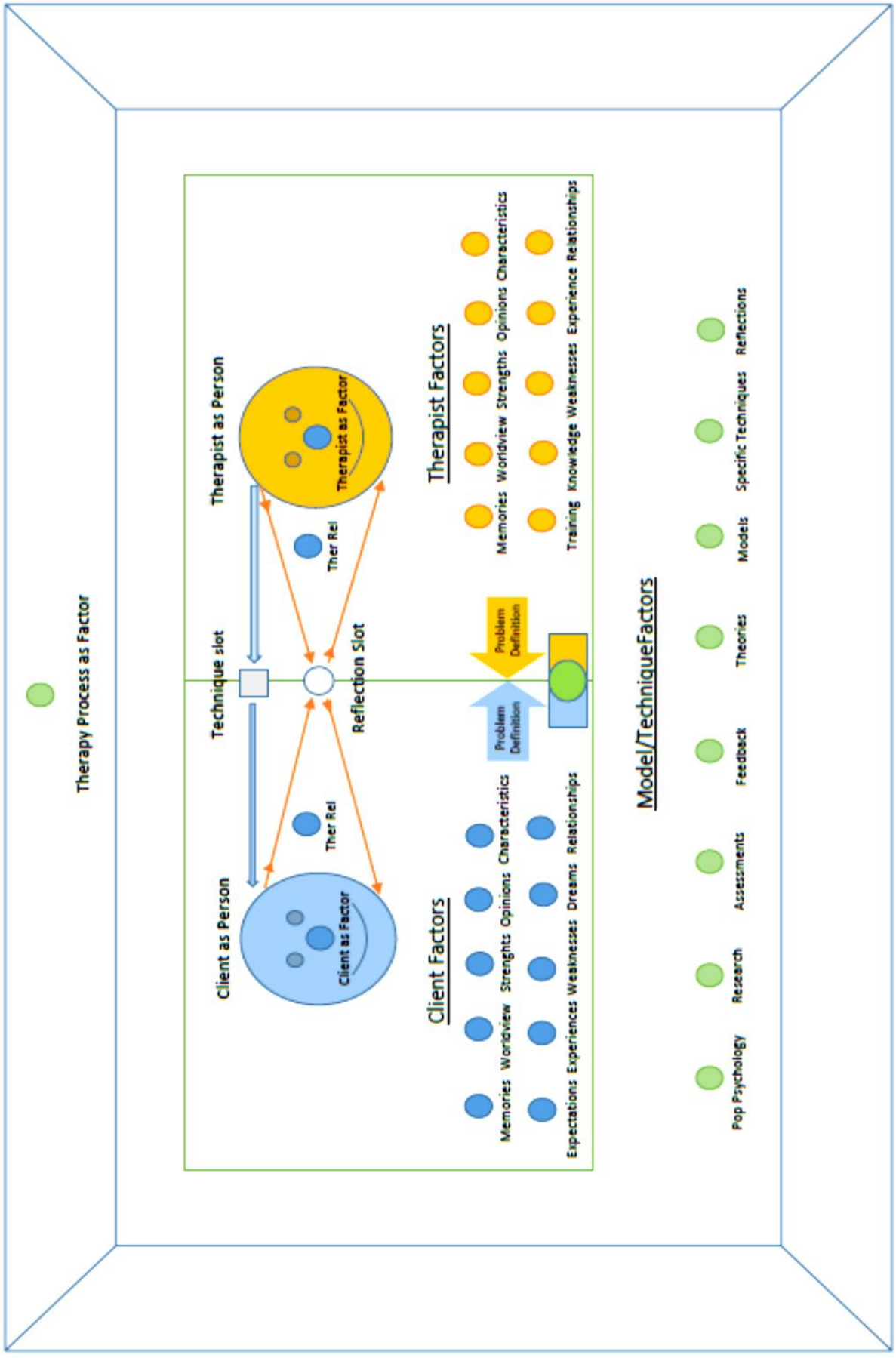

Figure 4.2 – A Social Constructionist Model of Therapeutic Factors

Considering her derived explanation, she may now ask for advice from friends and family or attempt to google the problem away. Any of these paths to a solution may be helpful since they may serve to broaden her worldview enough to allow for satisfactory solutions to become available. If not satisfactory then she may consider professional help in the form of medical consult or psychotherapy to 'treat' the problem away.

Thus, during the pre-therapeutic stage, the client experiences a problem for which there are not any satisfactory explanations that lead to satisfactory solutions. She finds herself in an experiential conundrum that requires a *different* opinion, perhaps a professional opinion in order for the problem to be resolved. This expectation of the client first signals that her own worldview is constricted and so were her prior attempts to broaden it; and second that there is hope that the psychotherapy process will provide something different in terms of explaining and solving the problem. In other words, through the act of consulting a psychotherapist the client communicates that she is open to reflection and that the relatively solid boundaries enclosing her worldview have turned into relatively permeable boundaries that will allow new perspectives to expand her existing worldview.

4.2 FORMATION OF THE THERAPEUTIC SUPRA-SYSTEM

The therapeutic supra-system forms when the client and therapist agree that they will engage in interactions to discuss the client's problems. The joining of the client and therapist gives rise to the definition of the nature of their relationship. This therapeutic supra-system cannot exist without mutual acceptance of its existence and nature by both therapist and client. Selvini-Palazzoli, Boscolo, Checchin and Prata (1980) and later Cecchin (1992) describe how this negotiation of the nature of the therapeutic relationship generally occurs on covert levels to define the client's and therapist's interactive roles in relation to one another (e.g. expert vs. leek; provider vs. consumer; equal allies; etc.) and determines alliances. When a therapist

remains unaware of the role he or she assumes in relation to the client, it may lead to the reinforcement of the existing worldview of the client and of the problematic patterns of behaviour.

During the formation of the therapeutic supra-system, the client reveals that there is a problem and shares her worldview of that problem with the therapist. The therapist in turn adopts a curious stance, what Anderson and Goolishian (1992) call a *not-knowing stance,* in order to understand the problem from the client's perspective. At this point, the social constructionist therapist should acknowledge that the client's worldview is one of a multiverse of worldviews that is informed by her previous experiences, personality characteristics, relationship history, character strengths and weaknesses, including all other client factors.

The therapist should also understand that the client's worldview colours her perception of the problem and sets parameters of the problem definition. These parameters of the problem definition then also delimit the possible solutions that are readily palpable to the client as well as to the therapeutic system at that point. Thus, in order for different solutions to become available, the therapeutic supra-system is reliant on an expansion of the definition of the client's worldview of the problem.

In the joining phase then, the client's and therapist's activities are centred on examining and reflexively considering all of the client-factors (including the client's problem definition) in the interactional space between the client and therapist. The therapist at this point may start to consider how the client's definition of the problem differs from his or her own understanding as informed by his or her knowledge of psychological theories, techniques and various other personal 'therapist factors'.

Through this process of sharing, the client (through sharing) and the therapist (through listening) open possibilities for negotiating and redefining their worldviews on the problem.

This is made possible only by the differences between the client's and therapist's worldviews. In the model presented in Figure 4.2, the joining process opens the space between the client and therapist as is represented by the *reflection slot*, the *technique slot* and the *problem definition*.

Because the therapist forms a worldview of the client's problem through the act of critically and reflexively listening to the client's explanation of the problem, the act of listening reflexively can be seen as a technique performed by the therapist. In the model described here, listening reflexively and various other therapeutic activities are conceptualised as techniques that are represented in the technique slot.

By sharing the problem, both therapist and client work towards reaching a mutual agreement of what the nature and definition of the problem is. Thus, by this collaborative effort to redefine the problem, it is no longer the sole property of the client's, but becomes the mutual property for which both client and therapist now take responsibility. Of course, it could also happen that the therapist creates the impression that he or she intends to take full responsibility for the problem, but this is not recommended.

Through developing a worldview of the client's problem, the therapist opens certain possibilities to explain the problem and how it may be solved. This brings into play both therapist factors and model or technique factors that can now be utilised in the therapeutic interaction. It is of crucial importance that the client also has an existing worldview for explaining the problem as well as having some ideas about the solutions he or she expects. The therapist can assist the client to articulate these expectations, if not already clearly defined. The client's worldview and expectancy factors form a crucial part of the negotiation between client and therapist in order to expand the shared worldview that develops as a function of the therapeutic interaction.

As a means to signal to the client that negotiations on the definition and nature of the problem has commenced, the therapist makes known his or her worldview as a possible explanation of the problem. The therapist's attitude becomes important here, in that the rigid therapist who believes in universal truths is vulnerable to adopt an authoritative role by imposing a worldview on the client. The overly flexible therapist on the other hand, may be vulnerable to forego his or her own worldview and adopt that of the client in order to reach agreement. This premature agreement actually undermines ongoing collaborative negotiations that lead to the expansion of the shared worldview.

In this model, it is important that the therapist reserves the right to hold his or her worldview of the problem, whatever its form may be. If his or her worldview is too similar to that of the client's, it may lead to therapeutic impotence. If the therapist's worldview of the problem is too different, it will not be compatible with the client's worldview. This refers to the orthogonality of the therapist's worldview and is determined through negotiation with the client. The therapist should thus be prepared to be flexible in the way his or her worldview is presented to the client.

Once the orthogonal worldview of the therapist is presented to the client, it provides the client with news of difference. Since the therapist's explanation of the problem is intended to affect the therapeutic interaction, the act of explaining can too be seen as a therapeutic technique performed by the therapist. The conceptualisation of explanation as a technique, implies that the therapist employs his or her worldview and explanation of the problem strategically and reflexively. Having awareness of each other's views and explanations of the problem, the client and therapist's worldviews on the problem can be reflected on in the space between them as a means to affect the mutually constructed, co-evolving problem definition.

The difference in their worldviews of the problem forms the basis of a structural coupling of ideas about the problem that allows for the gradual emergence of a shared worldview of the problem. This co-evolving shared worldview is different from both the client's and therapist's original worldviews of the problem, yet still contains elements of their original worldviews. In the model presented in Figure 4.2, the original worldviews are initially separate and as they move closer together over time, and as a function of the interaction between client and therapist, these worldviews eventually converge.

The converged problem definition is graphically presented to be different, in shape and shade, from the original problem definition to illustrate that it changes as a function of the negotiation between client and therapist (see Figure 4.2). It should also be noted that in practice, it is not necessary for the client's and therapist's worldviews to converge perfectly. Rather, what is sought in therapy is for the client's worldview of the problem to converge enough with that of the therapist so that the new frame would make alternative solutions available. This new explanation should make enough sense to the client so that the solutions that spring from it seem appropriate and satisfying to the client.

If this structural coupling between the client's and therapist's worldviews of the problem is negotiated successfully, it leads to the emergence of a new narrative that may serve to illuminate possible solutions to the problem. In other words, psychometric testing, specific theoretical descriptions, therapeutic techniques, interventions and/or rituals can now become plausible as useful elements that may form part of satisfactory solutions to the problem. Sometimes, however, the mere 'insight' gained from the new explanation of the problem opens a world of new solutions to the client. Thus, it is questionable if the enactment of a ritual or specific intervention, as envisioned by Fourie (2012) is necessary for all clients.

Having discussed the formation of the therapeutic supra-system, the various elements that form part of this system will now be discussed. These elements embody the common factors of psychotherapy and the model allows for them to be utilised in a flexible, yet meaningful way in a therapeutic interaction.

4.2.1 Therapist and Client as Persons vs. Factors

When the client or the therapist are spoken about as 'factors' in the therapeutic process it may be easy to forget that they also remain persons and that persons as factors are not to be confused with the persons themselves. Within this model, the distinction between a person and a person as a factor is based on the assumption that no therapeutic factor, including the person as a factor, has the ability of holding a worldview[7] or of reflecting on matters. It often occurs that factors become personified or persons become dehumanised in the technical language of science (Prilleltensky & Fox, 2009).

By making such errors, our focus in research and psychotherapy shifts away from the persons involved in the therapeutic interaction to the models, techniques and other factors as if these were the active agents in the therapeutic process.

The client and therapist as persons embody beings with subjective opinions, worldviews and capacities to reflect and communicate about therapeutic factors and about themselves and each other. As persons they possess agency to act, something that sets them apart from the therapeutic factors and gives them power over these factors. As persons, the client and therapist also holds the capacity to reflect on themselves as factors in the therapeutic process. Client and therapist as factors then embody the sum of how they perceive themselves

[7] Therapeutic models as factors are often personified as if they 'hold' certain worldviews and that the client interacts with a model rather than with a therapist, i.e. another person (E.g. Blow, Davis & Sprenkle, 2012; Simon, 2012a & 2012b). This error causes the focus to shift away from the persons involved in the therapeutic interaction to the models, techniques and other factors

and are perceived by the other, and as factors do not possess agency to perform, but are rather seen as objects of their own and each other's reflections.

A distinction of this nature implies that the client as a person may form a perception of the therapist as a factor. The client's perception of the therapist as a factor is important because it allows the client and therapist, as persons, to place this factor (i.e. the therapist as factor) in the interactive space between them to reflect on. Through this critical reflection, the persons involved are able to negotiate how the therapist as a factor impacts on their personal worldviews of the problem as well as on the co-evolving shared worldview of the problem.

By remaining an individual, but at the same time reflecting on the self as a factor in the therapeutic process, places the therapist in a position where he or she is able to receive feedback from the client about how his or her therapist behaviour and character impact on the client's worldview. Simultaneously, the therapist is able to talk about, and reflect on, himself or herself as a factor from an external meta-perspective, as if he or she were talking about another person entirely. Of course, the therapist can engage in a similar conversation with the client as a person about the client as a factor from a meta-perspective, and in doing so encourages the client to develop the skill of self-examination (also known as introspection).

Having a conversation about themselves as factors that influence each other may be quite powerful as it creates opportunities for both the therapist and client as persons to be critical of each other as factors, but at the same time be supportive of each other as persons. This allows for the provision of feedback while still nurturing the therapeutic relationship.

For example, a client complaining of 'depression and low self-esteem' may express anger towards the therapist for not having been responsive to her need for sympathy in a previous session. The therapist may seize this opportunity to invoke himself or herself as a factor in the therapeutic process to be reflected on and discussed in the space between. The

'therapist as an individual lacking sympathy' now becomes a potent factor that can potentially affect the client's worldview of her problem, but also the co-evolving shared worldview of the problem. The therapist as person may ask questions such as: "How has my failure to be sympathetic affected how you think of our relationship?" Followed by: "Would it change how you perceive yourself if I gave you more sympathy?" And finally: "How would it affect how you see your problem if I were to continue being unsympathetic?"

In all three of the foregoing questions the therapist as person adopts a curious stance regarding the effect of himself or herself as a factor on the therapeutic relationship, the client's view of herself as a factor and then the client's worldview of the problem. By providing answers to these questions, the client as a person gets to reflect on himself as a factor that affects his worldview of the problem. The problem, as defined from the client's worldview, is also being challenged in that the therapist suggests that it is malleable and dependent on how the client answers his or her questions. The therapist's reflexivity on himself or herself as a factor, also invites the client to critically reflect on her own problem narrative: "I [as a factor] need sympathy from others to feel that I am appreciated and worthy".

The reader is also encouraged to see that by adopting a meta-view of himself or herself as a factor, the therapist as a person is able to remain allied with the client as a person and thus avoids opposing the client in defence of himself or herself the therapist. The therapist merely acknowledges the client's experience of him or her as a factor and through the therapist's reflexive questions encourages a process of constructing meaning from this experience to add to the eventual goal of negotiating a shared worldview that allows for narratives with more satisfactory solutions.

By making this distinction of the self as a person and the self as a factor, the therapist is able to lead by example, defining the interactive space as one where it is acceptable to

acknowledge the self as a factor that at times impacts 'negatively' on the other and that there is something to be learnt by reflecting critically on the self as a factor while still appreciating each other as two persons engaged in a meaningful therapeutic relationship.

4.2.2 Reflexive and Critical Dialogue

In the foregoing text, much is said of reflexivity and critical dialogue as it pertains to the practice of psychotherapy. Reflexivity as a therapeutic stance has been widely advocated by social constructionists (e.g. Andersen, 1992; Hoffman, 1992; Tomm, 1987; Tomm, 1988) as being useful in the co-construction of new meaning.

The notion of the reflexive question stems from the philosophical ideas of Derrida (1982) surrounding the deconstruction of language in order to question the validity of the assumptions concealed therein. Tomm (1988) is of the opinion that any question a therapist asks stems from an intent that is either acknowledged or unacknowledged. As such a reflexive dialogue is intent on questioning the automatic presumptions that are revealed in the client's dialogue about the problem, the self and his or her relationship to the world and others (Tomm, 1988). For this type of reflection to occur, it is necessary that the dialogue is critical, meaning that its participants (or at least one of them) are/is committed to entertaining the possibility that the held assumptions may be unwarranted.

Such a critical and reflexive dialogue then sets a conversational context in which alternative definitions, narratives and worldviews may be considered in addition to the initially accepted ones. Of course, through reflexive and critical dialogue these alternative definitions, narratives and worldviews of the problem can and should also be scrutinised for the client to consider whether these may be more or less satisfactory, useful or healing. Tomm (1987) therefore believes that a reflexive dialogue is less confrontational and more inquisitive and

invitational, whereby the client is invited by the therapist to engage in a scrutiny of the effects of that client's generally accepted and unquestioned narrative of the problem, the self, the world and others. The effects of reflexive questions tend to turn dialogues into creative and generative interactions from which new meaning can emanate.

Tomm (1987) outlines and discusses in depth various forms of reflexive questions that may be utilised in a reflexive and critical dialogue. These include, but are not limited to:

- Future oriented questions
- Observer perspective questions
- Unexpected context change questions
- Embedded suggestion questions
- Normative comparison questions
- Distinction clarifying questions
- Questions introducing hypotheses
- Process interruption questions

It is beyond the scope of this thesis to discuss the structure and purpose of every form of reflexive question, but rather to explicate the general structure and effects of reflexive questions. As mentioned before, through posing a reflexive question, the speaker announces his or her critical stance of a subject, thereby inviting his or her audience to engage with the doubt raised. For instance, a therapist may invite a client into a reflexive dialogue on the meaning of his anxiety *disorder* for his perceived sense of self by asking a normative comparison question such as: "What do you understand by the term *disorder* and how does this understanding affect where you fit in in relation to others [who are presumably normal or anxiety ordered]?"

The reflexive question communicates a speaker's intention to critically reflect on the effects of utterances (as carriers of our assumptions) on our understandings of our problems, ourselves and the world. As a by-product, the reflexive question also serves to stimulate the dialogue as to how the aforementioned notions about problems, ourselves and the world may be different if we held different assumptions. The reflexive question is different from a negating question in that it raises doubt in a held assumption and invites a participative generation of unspecified alternatives. A reflexive stance then closely approximates the not-knowing stance, indicating that the therapist does not presume to have the luxury of knowing the correct assumptions to hold, but rather accepts that there may be numerous assumptions with varying effects on the client's view of the problem, the self and the world.

A negating question on the other hand communicates that the speaker disagrees with a specific assumption and seeks to impose an alternative view on his or her audience. The latter type of question serves to negate one perspective (i.e. that of the audience) and promote the perspective of the speaker, thereby framing the interaction as one of opposition. As an example, the said therapist may respond to the client's notion of being anxiety *disordered* by asking the negating question: "Why not substitute the rather debilitating word *disordered* with the word *challenged*?" Although such a question may challenge the assumption of the client, it invites the client to adopt a different assumption (i.e. that of the therapist), without engaging in a reflexive dialogue of what these different phrases would mean to the client or how it would impact on his perception of the problem, the self or the world.

In the social constructionist model of psychotherapy outlined in this thesis, a general reflexive and critical stance is promoted in order to stimulate a critical and reflexive dialogue between client and therapist. By utilising the power of reflexive questions, a therapist may go a long way to facilitate a reflexive dialogue. However, as with all therapeutic techniques, reflexive questioning is one among an array of types of questions (i.e. techniques) that the

therapist may enlist. It should, however, be noted that by merely asking reflexive questions, the therapist is not guaranteed that the conversation will be reflexive and critical. Conversely, by asking other types of questions (such as strategic, lineal or circular questions) the therapist may still retain a generally reflexive stance through his or her commitment to acknowledge and articulate the assumptions that are promoted by any form of question posed in the dialogue.

Thus, the model discussed here discriminates between a reflexive question and a reflexive dialogue, the former embodying a therapeutic technique, while the latter signifies the therapist's commitment to critically and reflexively engage in participation with the client on whatever question is raised in therapeutic interaction (including all types of questions, techniques and other common factors).

4.2.3 The Space Between

As discussed above, the therapeutic relationship is established when agreement is reached between a client and a therapist to reflect on and exchange worldviews of the client's problem. This process of communicating their inner experiences and understandings of reality results in a shared or mutual space between client and therapist where their worldviews meet (Becvar & Becvar, 2000). In the model proposed here, this space is called the *space between* as it refers to the point of intersection of the client's and therapist's inner worlds.

The 'space between' is of utmost importance in the therapeutic process, as it is here where client factors, therapist factors and all other therapeutic factors converge when the therapist and client reflexively discuss and negotiate the meaning of these factors for them as persons and for the problem of therapy. Considering the concept of structural coupling, it is in the 'space between' where the client and therapist become structurally coupled in the hopes of influencing each other's worldviews in ways that may benefit the client.

The therapist assumes much responsibility in this regard, as it is he or she who must remain consistently aware of this 'space between' so that it may be utilised optimally and reflexively in the process of therapy. When certain factors bearing on the worldviews of client and therapist become salient, the therapist should bear the responsibility of placing those factors in the 'space between' so that it may be critically and reflexively examined for its part in constructing the current worldview of the problem. It is also in the 'space between' where new meaning may be 'discovered' in relation to any specific factor that is reflected on. The 'space between', therefore, is useful for the 'discovery'[8] of metaphors, images, discourses, etcetera that can be utilised in the construction of a new narrative to inform a different worldview of the client's problem.

For instance, a client may be unaware of the extent to which her support system, as a factor, bears on her worldview (and narrative) of a problem such as a post-traumatic stress reaction. In discussing her experiences following her trauma, the client may discuss how she becomes easily irritated by others and how this difficulty impacts on her significant others, leading to guilt. Here the therapist has a multitude of client factors to which he or she can react (i.e examine in the space between), including diagnostic factors (PTSD), personality factors (irritability), interpersonal factors (relationship with others). Each of these factors may reinforce the existing worldview of the client or they may be utilised to critically and reflexively question the current worldview.

By critically reflecting on her irritability in the space between, it may come to light that the client's irritability stems from her worldview that others are not concerned about her troubles, but that their enquiry of her emotional status rather communicates an expectation to

[8] It should be understood that, from a social constructionist worldview, discourses, etc. are not discovered, but are co-constructed by a client and therapist's interactive negotiation in the space between. It may appear, however, that these elements emerge as if 'discovered' and for the sake of therapy it may even be useful to tolerate this illusion of 'discovery' as long as this does not restrict the therapist's openness to other useful discourses, images, metaphors, etc.

be “okay” as quickly as possible in order to reduce the burden on others. The reflexive and critical stance of the therapist provides a context for the revelation of previously unquestioned discourses such as ‘personal worth’ and ‘burdening of others’ and the image of the self as ‘an unfortunate inconvenience’. Such discourses may dictate the client’s personal narrative and worldview of the self as being secondary to others. The critical and reflexive examination of these discourses and images and their effects on the client’s worldview of the self is likely to expose new discourses such as ‘alliances to the self versus others’ that can be weaved into a narrative and worldview that reveals a different conceptualisation and solution to the problem of irritability.

Such different narratives may include that the client’s irritability may not necessarily stem from others’ lack of understanding and concern, but from the fact that she places herself second to others and thus has neglected her own needs by being more concerned with the needs of others. Specific therapeutic techniques, such as guided relaxation, may now be employed as a means to reduce the client’s irritability with herself in order to set the context to restore her alliance with, and make peace with, herself. If the therapist merely chose to reduce the client’s irritability by invoking a therapeutic technique of guided relaxation, it may likely reinforce the client’s worldview that she is an inconvenient burden to others and it is thus questionable as to whether any satisfactory long-term relief would result.

It is important to note that the space between should be utilised for the revelation of the client’s current worldview and to construct a new worldview. It may be tempting for the therapist to develop a narrative and worldview of the problem that he or she feels may be appropriate for the client’s problem and reveal this to the client without going through the fuss of reflection with and questioning of the client. However, a different narrative and worldview of the problem is much more likely to be satisfactory when the client feels she was part of the ‘uncovery’ of that narrative and worldview through painstaking reflection in the space between.

Finally, it may be possible that the client seeks to place, either knowingly or unknowingly, specific factors in the space between for reflection. The therapist would do well to be responsive to the client's attempt and reflect on its meaning at that specific point in time, instead of just allowing or dismissing it. If the client continually clashes with the therapist on what should be reflected on in the space between, it may be appropriate to reflect on the therapeutic relationship as a factor in the space between. Such a reflection may reveal certain interactive patterns between client and therapist that may bear on the worldview of the problem.

For example, the client may tend to be argumentative or extremely agreeable which may provide clues to their worldview of themselves in relation to others when reflected on critically. This type of reflection closely resembles the psychoanalytic business of dealing with transference and countertransference.

Depending on the need of the situation, the space between may be utilised to reflect on either the client's or therapist's experience of the therapeutic relationship. This process of giving and soliciting feedback to and from each other may impact emphatically on both the client's and therapist's worldview of the problem as well as on the co-evolution of their shared worldview of the problem. It is through this feedback in the space between where the client and therapist gets to view themselves as persons affecting another person and affecting a mutual process or worldview.

By reflecting on themselves as factors in the process of constructing a mutual worldview, the client and therapist have an opportunity to experiment with different roles and different ways of behaving toward each other as well as feedback on what the effect of this experimentation was on the other. What is important is that the space between remains a mutual space that is not dominated by either the client or the therapist.

4.2.4 Worldviews as Factors

The social constructionist viewpoint assumes that any awareness, explanation or formulation of human experience is unavoidably subjective and as such requires the person to order these experiences and interpret them in a meaningful way. Therefore, communicating what one knows about a specific experiential problem requires one to hold a specific worldview (i.e. theory about the world, oneself and others) from which to generate descriptions and explanations of that problematic experience.

The worldview of a client may be informed by layman's knowledge, superstitions, religious ideas, popular psychology, inherited knowledge, scientific knowledge and/or personal experience. The therapist's worldview generally is informed by general philosophical assumptions (formal epistemologies), specific working models of psychopathology and psychotherapy and/or specific therapeutic techniques. However, the therapist's worldview is likely to be influenced by subjective factors as well, including personal experience, likes and dislikes that affect how he or she is inclined to explain the problem from a scientific viewpoint.

What is important to consider in terms of worldviews as factors is how a worldview may affect the possibilities for action of the individuals involved. Also the use of certain explanations, metaphors, discourses, techniques and all other therapeutic aids may be limited by specific worldviews or may be encouraged by other worldviews. The worldviews of the therapist and client therefore may affect how, and when, certain factors are reflected on and how, and when, certain techniques or explanations may be invoked to affect the shared worldview of the problem.

For example, a therapist who formulates his or her worldview of the problem from an object relations therapy model may open possibilities of reflecting on the client's internal representations of relationships with significant others and how this may impact on the problem

definition. On the other hand, a therapist whose worldview of the problem is informed by a behavioural model may open possibilities for reflecting on past lessons learned by the client about herself and how such lessons may impact on the problem. These different worldviews of the therapist may lead to a different shared worldview of the problem that may lead to different solutions. The first narrative (based on object relations) may inform solutions based on developing more realistic representations of relationships, whereas the second may inform solutions based on techniques to assist the client to learn new lessons about her worth as an individual.

Although it may appear that the therapeutic model directs the therapist's actions, such a unilateral punctuation is misleading and potentially disables the therapist's agency. Instead of a worldview directing his or her behaviour, the therapist is advised to consider a worldview as colouring his or her perceptions and actions in certain meaningful ways. The worldview of a therapist gives rise to one of many potentially helpful narratives for making sense of the problem and solving it. When it directs a therapist's behaviour, however, that therapist is in danger of mistaking a narrative for the truth and this may lead to rigid approaches to therapy. Conversely, the therapist's interpretation of a model (as affected by his or her idiosyncratic worldview) necessarily changes that model so that his or her interpretation and execution of therapy from that model is different from that of any other therapist's.

Keeping these matters in mind, one can appreciate how client and therapist worldviews as factors hold potential for shaping the shared worldview of the problem. When taken for granted this effect on the shared worldview is insidious, but when the therapist is mindful to critically reflect on his or her own worldview and the client's worldview in the 'space between', an opportunity is created for them to actively utilise their worldview to construct a shared worldview of the problem.

4.2.5 Model/Technique Factors

Model and technique factors include any act that is deemed to be, or intended to be, therapeutic. Stated differently, these factors include any act that is strategically employed by the therapist to facilitate the process of negotiation of a shared worldview of the problem. Among these factors are specific theoretical explanations, models of therapy, research and research findings (including statistics), psychological testing and results, feedback, reflections, mirroring, listening, pausing, remaining silent, specific therapeutic stances (including directive-, not knowing-, empathic stances, etc.), hypnosis, EMDR, among many others.

The model is designed to illustrate that the various therapeutic factors can be reflected on critically in the space between, so that the therapist and client express their respective views on how each of these factors impact on their worldviews of the problem as well as the problem narrative. As a result of this reflexive approach, the reflexive dialogue between client and therapist often focus on the therapist's theoretical explanation of the problem. This entails that the therapist places his or her guiding model in the 'space between' for critical reflection.

By making his or her problem narrative explicit, the therapist offers an alternative "scientific" explanation of the problem that may serve to alter the client's problem narrative. The general idea of such a move is to present the client with a sufficiently different view of the problem so that it may stimulate dialogue on the differences in worldviews.

Furthermore, in the model proposed in Figure 4.2, one can distinguish between the performance of a technique on the client (which may have a specific strategic value, e.g. to illustrate some point) and the reflection on that technique in the 'space between'. The former has a unidirectional nature, (i.e. something the therapist does to the client for some or other purpose). The implementation of a technique, however, is usually accompanied by the latter,

that is a reflection on the technique and its effects in the 'space between' so that its impact on the worldview of the problem is considered reflexively and critically.

Of course, failure to reflect on the performance of some technique and its effects in the space between does not preclude it from influencing the co-evolving shared worldview of the problem. Examples where the intentional employment of technique without reflection in the space between is carried out effectively are found in the directive therapies of Milton H. Erickson (see Haley, 1993; Haley, 1963).

By its nature, the therapeutic interaction and the space between allows for the constant exchange of ideas based on the client's and therapist's differing worldviews. This implies that constant feedback and constant reflection occur between client and therapist. This is different from feedback and reflection when employed as techniques. The latter implies the strategic and timed use of feedback or reflection at a specific point in time with the mind-set of achieving some therapeutic goal. General feedback and reflection, on the other hand, are necessary components of any human interaction that usually occurs outside of our conscious awareness.

For instance, to express an idea, a person needs to reflect on some matter, the self and his or her relationship to that matter so that an opinion or idea can be formed on that matter before it can be expressed. By expressing an opinion or idea, a person is necessarily giving feedback to the external world about his or her internal world. In this model of psychotherapy, the therapist is required to remain constantly aware of the ongoing reflexivity and feedback involved in the interactive process so that they may be employed consciously in the process of co-constructing a shared worldview of the problem.

Given that the proposed model represents a social constructionist explanation of a change process in psychotherapy, it is aimed at promoting an understanding of how change can be facilitated through the reflexive dialogue on various therapeutic factors. As such, it should

allow a therapist to utilise any technique and model of psychotherapy, including cognitive behavioural models, psycho-analysis, family systems models, etcetera. It does, however, call on psychotherapists to reflexively accept these models and techniques as possible explanations of the client's problems, rather than get attached to these as offering absolutely true accounts of the problem and its solutions.

4.3 CONCLUSION

Given the weaknesses of the evidence based approaches and the common factors models of psychotherapy that were discussed in the previous chapter, this chapter was dedicated to outlining a different model for viewing the process of psychotherapy. The epistemological assumptions that form the basis of this model emanate from a postmodern worldview and ideas from ecological and social constructionist perspectives were utilised to inform practical methods of utilising common factors in a social constructionist model of psychotherapy.

It is argued that the difference in client and therapist worldviews form an integral part of the therapeutic process, in that a critical and reflexive discussion on their different views on various common factors allow them to co-construct a different worldview of the problem. This worldview may not be 'more true' than the client's original worldview of the problem, but may be relatively more useful to the client as it may afford him or her a wider array of solutions than the original worldview. This model then assumes that there may be a variety of legitimate worldviews for explaining a specific problem, and that it is the task of psychotherapy to construct the most useful and satisfactory worldview for finding solutions for the client's problem.

Thus, departing from the modernist view of ultimate truths, this model seeks to embrace different views and explanations of reality as having potential value for adding meaning to the client's experience of his or her problem. This model then also seeks to incorporate both specific therapeutic factors as well as common factors of psychotherapy as crucial elements in the therapeutic process that may be utilised to construct a different, more useful worldview of the problem through critical and reflexive dialogue between two subjective and reflecting individual persons, (i.e. therapist and client).

With the goal of demonstrating the application of the model described above, the focus in Chapters 5 and 6 shift to the presentation of case illustrations in clinical practice.

CHAPTER 5

CASE ILLUSTRATIONS: A SOCIAL CONSTRUCTIONIST MODEL OF THEAPEUTIC FACTORS IN PRACTICE

In the foregoing chapter, a social constructionist model of therapeutic factors was explicated in terms of a pre-therapeutic stage as well as the formation of a therapeutic supra-system. The latter consists of various therapeutic factors that can be mobilised in the co-construction of the therapeutic narrative that is negotiated between therapist and client. These factors include everything and anything brought to the therapeutic process by both the therapist and client and then also contextual factors that arise as a function of their specific local interaction.

The various factors were grouped together as *client factors*, *therapist factors*, *model/technique factors*, *problem definition as a factor*, *interactional process as a factor* (including the space between and the technique slot), and finally *the supra-therapeutic system as a factor*. Following from the theoretical discussion of these various elements of the social constructionist model in question, this chapter is dedicated to illustrating the workings of the model through various case illustrations.

5.1 INTRODUCTION TO CASE CLIENTS[9]

Each of the cases included in this chapter was chosen due to the clarity with which it highlights some part of the guiding model. Since there is much overlap between different cases in terms of the therapeutic process, segments of cases are emphasised as they pertain to the

[9] All case clients were seen in psychotherapy with the author as the therapist and all clients gave consent for their narratives to be included in this thesis. All names and personal particulars have been changed to ensure the anonymity of clients.

element of the model under discussion. The reader is invited to keep in mind that a successful therapeutic process is likely to require the client and therapist to utilise multiple therapeutic factors in the construction of the new therapeutic narrative.

5.1.1 Her Sister's Keeper: Zanele's Depressive Duties

Zanele is a 29 year old black female who lives in the Johannesburg CBD with her niece. She is single and has recently ended an eight month long relationship. She has no children, but finances the care of her deceased sister's five children as well as her mother who all live in a different province. She works in the project management field and holds a certificate in project management as well as a Bachelor degree in accounting. She describes herself as an active Jehova's witness.

Zanele first consulted the clinic[10] in 2014 as she experienced difficulties "handling her own stuff" and felt like her "world was crumbling". She was eventually diagnosed with a Major Depressive Disorder and co-morbid alcohol abuse and was admitted to a local private psychiatric clinic for treatment. Her psychotherapeutic process included inpatient sessions (three sessions per week over three weeks) and weekly outpatient sessions for a period of six months following her discharge from the hospital.

5.1.2 Marcus Who Lost His Mojo

Marcus is a 26 year old white male who lives in the northern suburbs of Johannesburg. He is single and despite having numerous friends has recently resorted to social withdrawal together with a somewhat apathetic and nihilistic attitude to life. He holds a good job in the

[10] Sandton Psychology Centre

financial field in which he is quite successful despite never having completed a university degree. He does not have any children or dependents.

Marcus first consulted the clinic in November 2013 with complaints of "feeling numb and disinterested in life". He struggled to find any meaning in life and thus also did not feel passionate about any area of his life. He was previously diagnosed with a Major Depressive Disorder and had underwent therapy as a child to assist with behavioural problems at school. His psychotherapeutic process consisted of weekly outpatient sessions for a period of five months.

5.1.3 Lost in Transference: Heinrich's Path to Self-Acceptance

Heinrich is a 45 year old male who shares a house with his long-time friend and her girlfriend in the eastern suburbs of Johannesburg. He has been single for a few months following a complicated short-term relationship with a younger Arab man in the Middle East. Before this he had been on the online dating scene where he pursued numerous no-strings encounters with men in a Middle Eastern city. His first relationship, which lasted for 10 years, was characterised by extreme physical and verbal abuse from his partner. Heinrich reluctantly admits to being gay, but has only told a select few people, excluding his parents and colleagues as he fears being judged for what he terms "unnatural sexual acts". He has been working as a writer in the business sector since he returned from the Middle East in 2013.

He first consulted the clinic in October 2013 to help prevent him from becoming suicidal yet again. His visit was prompted by a tumultuous history of abusive relationships, isolation, interpersonal rejection as well as severe financial debts he incurred in order to secure his relationship with the young Arab man he was secretly dating. Due to these extreme pressures he eventually reached a level of desperation that lead him to attempt suicide by

cutting his wrists. After a two week stay in a psychiatric unit and a few nights in an Arab prison, Heinrich eventually fled back to South Africa fearing prosecution for his suicide attempt. His psychotherapeutic process comprised of weekly psychotherapy sessions for a period of more than 12 months.

5.1.4 When Love and Hate Collude: Mandy's Emancipation

Mandy is a 36 year old white female who lives in the northern suburbs of Johannesburg. She is separated from her physically and verbally abusive boyfriend after a relationship of seven years. She has a daughter of nine years old with her ex-boyfriend. She works as an office manager and reports that her boss is very supportive of her.

Mandy first consulted the clinic mid 2014 after she had a fall-out with a colleague (also a friend of hers) at work. Her boss suggested that she seek professional help to deal with the tremendous anger she expressed during this fall-out. According to Mandy she agrees that she tends to become very emotional, aggressive and tends to overreact when provoked by other people. She attributes these difficulties to having had a generally 'bad life' where she was rejected by her biological father, molested by her step-father, accused by her mother as being a liar and raped at the age of 13 years, before resorting to a life of sexual promiscuity and a series of bad choices in men. Her psychotherapeutic process consisted of weekly sessions and concluded after a period of 2 months.

5.2 THE PRE-THERAPEUTIC STAGE

Primarily, the pre-therapeutic stage is characterised by a sense of discontent in the client regarding one or more incidents in their lives. This discontent sprouts from an unsatisfactory and restrictive problem narrative, meaning that the client's mental frame for understanding

their life situation leads to negative feelings and/or symptomatic expression. In the context of the social constructionist model of therapeutic factors, restrictive problem narratives do not mobilise client factors sufficiently in order to resolve the client's problem and thus clients frequently make statements such as: "I'm in need of a different viewpoint" when asked about the reason for their consultation. In eco-systemic terms, this signals the need for feedback geared towards disrupting the unsatisfactory status quo, and the therapist personifies the source of information that may hopefully achieve the desired systemic perturbation.

In the case of Zanele, her restrictive problem narrative was communicated as a tendency to place her own needs last in order to take care of her family. As a result she experiences a sense of disappointment in herself for not progressing far enough in life. Already one can identify various client factors that are at odds with each other, causing a disharmonious problem narrative: The first client factor is Zanele's personal desires, wishes and needs that are at odds with a second grouping of client factors, familial duties and -expectations. Both these factors later prove to be very important to Zanele, and thus it is a major task in the therapeutic process to construct a narrative where these factors are not at odds.

Furthermore, Zanele's case also illustrates how a restrictive problem narrative leads to symptomatic expression. After stating her problem narrative, the therapeutic conversation turns to explore how the restrictive problem narrative links to specific psychiatric complaints. Zanele reported the following psychiatric symptoms: Depressed and irritable moods, loss of interest and pleasure in hobbies and interests, social withdrawal, low energy, a lack of motivation, poor concentration, poor self-esteem, suicidal ideation and anxiety related to her feelings of inadequacy. It is important to note here that clients often do not make explicit associations between their restrictive problem narratives and specific psychiatric complaints. The therapist therefore has to facilitate this association, and thus starts with the construction of a different problem narrative.

In the case of Zanele, she attributes her difficulties to the unfair life situation that has befallen her after her sister's death. In exploring this piece of life history it came about that Zanele, who had been a hard worker all her life (in order to pursue a successful career) had to put her dreams on hold to take care of her sister's five children. She described feeling cheated by life as she now has to suffer as a result of her sister's irresponsible behaviour. Zanele refers to the fact that her sister had been "promiscuous", had five children before contracting HIV that later caused her death. In terms of therapeutic factors, the latter revelations introduce another client factor to be explored in later sessions: That is personal experiences of life and relationships (*life is unfair* and *others cannot be trusted*).

Finally, the pre-therapeutic stage also frequently has an isolated quality as clients often report in the first session that their problem has left them feeling alienated from others or that others do not understand what they are going through or that they do not feel comfortable sharing their problem with significant others due to a variety of potential reasons. Whatever these reasons may be, the result is that clients tend to sit with the problem in their own hands and do not have the benefit of self-reflection with the assistance of an outsider's opinions.

Thus, clients tend to fall into a rut, using the same solutions to the same problems and expecting different results. For instance, Zanele reports experiencing poor social support and not having anyone she can speak to about her difficulties. She describes feeling too guilty to share her difficulties with her mother, as her mother is partly responsible for pressurising Zanele.

From the above then, one can see that a combination of conflicting client factors (personal needs vs. family expectations, personal experiences in life and relationships, personal identities, etc.) lead to a restrictive and unsatisfactory problem narrative ("I am a failure as I have not achieved anything") that then also restricts the possibility of further mobilising

potentially helpful factors due to the isolating nature of restrictive problem narratives. The result is that the client sits with a problem to which she feels there is no solution. Furthermore, the problem alienates her from the people who might potentially help resolve it. This state of helplessness is usually what motivates clients to seek professional help in the form of psychotherapy.

5.3 FORMATION OF THE THERAPEUTIC SUPRA-SYSTEM

The therapeutic supra-system theoretically forms the moment the client and therapist agree to discuss the client's problem narrative in a therapeutic interaction[11]. The therapeutic supra-system can thus be defined as a system that usurps the boundaries that confines the client's problem narrative, thereby allowing for new information to enter and perturb his or her system of understandings of the problem. The newly drawn boundary around therapist and client ideally should be closed enough to allow for a sense of safety, yet open enough to break the isolation caused by the initially restrictive boundary surrounding the client's problem narrative.

An example of this boundary expansion is illustrated in the case of Heinrich. Upon his first visit to the clinic he was notably tense and conversed in a reserved manner, being careful to word his complaints in such a way as to appear at least somewhat 'socially appropriate'. The nature of the clinical intake affords the therapist with an interviewing structure that allows him to ask sensitive questions of a personal nature with the understanding that it is general protocol.

[11] Therapeutic interaction here denotes any conversation and/or interaction that serves to broaden the clients' problem narrative and thus their meaning is much broader than purely the employment of therapeutic techniques. As such therapeutic interaction may even include an intake assessment when this causes clients to experience their problems in a new way (also see the section on reflexive and critical dialogue in Chapter 4).

Of course these questions also serve a different interactional function as they allow for the breaking down of the boundary that isolates the client's problem narrative.

When asked about his relationship history, Heinrich was confronted with the cause of his initial tension. His efforts to appear 'appropriately masculine' was met with an explicit invite from the therapist to define his sexuality in terms of his sexual orientation. "Tell me about the last relationship you were in?" was met with: "The thing is, it is complicated…I was in a ten year relationship with my previous partner… [Pausing] he is a man… [Squirming in his seat while choking out the words]". Heinrich's discomfort in revealing his sexual orientation is a clue to the immense anxiety his restrictive problem narrative is causing him, and also of how isolating the rigid boundary surrounding that narrative can be.

By asking these difficult and personal questions the therapist is not merely gathering information, but is presented with an opportunity to chisel through the boundary that isolates the client. Furthermore, the way the therapist goes about asking these questions and how he or she receives the answers to these questions also helps to define the nature of the newly expanded boundary that now encapsulates both therapist and client.

In the case of Heinrich, the therapist, being aware of Heinrich's discomfort in answering this particular question about his sexual orientation, was careful not to be overzealous in his approval of the information (as is often a social reaction to news of someone coming out), yet tried to communicate a casual acceptance of the information (as if it happens all the time). Of course different therapists will have different reactions as their reactions are a function of who they are as individuals and their values. This refers to therapist factors and will be discussed in more detail in the next section.

The interaction between Heinrich and the therapist illustrates how Heinrich's personal identity as a 'deviant' together with his expectations of social reactions (both client factors)

meets with the therapist's reaction of casual acceptance of his sexuality (a therapist factor). The therapist's acceptance then erodes the boundary around the restrictive problem narrative, draws a new boundary around himself and Heinrich and feeds new information into Heinrich's restrictive problem narrative and challenges notions he holds about his own deviance (*Am I really that deviant if he accepts me so easily?*).

It is interesting to note that, in a later session Heinrich revealed that he was perturbed by the therapist's casual acceptance of his sexual orientation and felt he should have made more of this information than he had. This afforded the therapist with the opportunity to reflexively discuss that interaction with Heinrich so that they could define why the therapist reacted the way he did. Here the therapist chose to reveal his comfort with homosexuality as a function of him frequently engaging in contexts where homosexuality is a norm rather than an exception (another therapist factor).

The therapist then continued to ask him about how he thought people close to him (client factor) might react to his sexual orientation (client factor) and shared stories about his personal experience (therapist factor) of friends 'coming out' to their significant others. By including outsiders in the therapeutic conversation, the safe boundary surrounding the therapist and client is being defined as relatively open to trustworthy outsiders and allows for Heinrich to consider in what set of circumstances he might feel more comfortable to let others in. This is important in order to prevent the therapeutic supra-system itself from becoming restrictive and closed to outside information, a circumstance that may lead to client dependence and the therapist getting stuck.

As can be seen from the foregoing discussion, many client, therapist and therapeutic factors are available to facilitate the process to expand the rigid boundaries that isolate clients' problem narratives. These factors can be employed in creative and varied ways depending on

the therapist's knowledge of these factors and his or her willingness to engage these in the therapy process. For these factors to be employed, it is necessary for them to be reflexively discussed in the space between.

5.4 THE SPACE BETWEEN

As soon as the client and therapist meet and agree to discuss the client's problem, it opens a reflexive interactional 'space between'[12] them where various client, therapist and therapeutic factors can be discussed. The formation of the 'space between' depends on an agreement by two individuals that they are going to consider each other's views while revealing their own. It is not necessarily a verbal agreement, but can occur when the presence of either one causes reflection on a matter in the other.

As an example of the formation of the 'space between', consider the case of Mandy. Upon her first visit, much of the session was spent on gathering clinical information. This information included critical information on her childhood, including her being rejected by her father and then a period during which she was conditionally accepted and adored by men in her life (the condition being that they sexually exploited her). Although the conversation never explicitly formulated the impact of these events on her, the mere enquiry into these matters communicated to the client that somehow they might be related to her problem and thus had the power to unlock the reflexive space between.

During our follow up session, Mandy very excitedly announced what a big impact our first session had on her. The therapist, feeling quite surprised, enquired into what had happened to ignite this shift and it was revealed that the questions asked surrounding sexual abuse in her

[12] This space between is also referred to as a reflexive slot, indicating its purpose as a space for holding material (aka therapeutic factors) for critical and reflexive discussion.

childhood and later adult relationship choices incited her to think in her spare time: "Maybe somehow these things are related?". Matters relating to her sexual behaviour and choice of partners, which used to perplex her, suddenly had some connection to earlier experiences and in this way shed light on her current behaviour.

This reflexivity on the part of clients often occurs during the process of therapy without the therapist intending for it to occur. As such it is also considered to be a therapeutic factor in the form of therapeutic progress or feedback that needs to be reflected on in the 'space between' when it arises.

The goal of such a reflexive dialogue would be to weave this progress into the evolving problem narrative, thereby 'learning'[13] something more of how this problem narrative functioned in the past and how its changes are shaping the client's experience of her problem. This in essence broadens the client's restricted and unsatisfactory worldview of the problem.

It would have been easy to just let Mandy's excitement slip by as a serendipitous success, but the therapist working within this model would do well to reflexively engage with any type of feedback (good or bad) in the reflexive slot. For instance Mandy was asked: "How do you explain this different feeling and/or perspective…what could have happened to bring this about?" Often clients are at a loss to explain what changed. In such a case, the therapist may comment: "You say it is just talking to someone, but you visibly look different and it makes me think that you perhaps have learned something new about your problem".

The latter comment draws on various factors including the client's feedback on progress (therapeutic factor), therapist feedback (you look different), client's opinions and changes in the problem narrative as a factor. These factors then become the focus of critical reflection in

[13] The term 'learning' is used cautiously here, since the therapist and client are not actually learning something about the problem narrative as if it existed out there on its own, but in fact actually constructs its functioning and changes as their conversation unfolds. Often it is helpful to allow clients to hold on to the illusion that they are uncovering truths rather than constructing them, since it adds more legitimacy to their newly found perspective on matters.

the ‘space between’ for consideration of how they affect the client’s understanding of the problem.

It is useful to point out here that the model is intended to illustrate that the various therapeutic factors can be placed in the space between for critical reflection, so that the therapist and client may examine these factors as if they were physically on the table between them. Such an externalisation of therapeutic factors allows them to express their respective views on how each of these factors impacts on their worldviews of the problem as well as on the problem narrative.

In Mandy’s case, for example, the therapist utilised the space between to externalise his theoretical or clinical formulation of her problem (a therapist and/or model factor) in the space between:

> *From everything you have told me about your past, one can say from a clinical viewpoint that you have experienced numerous rejections by men in your past and only found acceptance on condition that you are exploited by men. I’m wondering what you would make of such a statement, would it hold any value to you?*

In the latter comment, it is important to note how the therapist externalises the theoretical viewpoint without investing too much confidence in it as an ultimate truth. In essence, he is inviting Mandy to reflexively consider its usefulness to her in terms of her understanding of her problem. Here the differences between original client worldviews and therapist worldviews become important as the therapist needs to use whatever is in his or her arsenal of explanations to give the client something that is different, but not too different from

her worldview so that they may sufficiently alter her problem narrative to allow for change to occur.

Mandy's response to the therapist's question was to burst out in tears, since she now recognised that she relinquished herself for exploitation in order to secure 'love and acceptance' by men. Here another client factor arises in the form of client feedback. Notice also that the problem narrative is changing shape from "I am a victim of abuse and rejection" to "I am contributing to my own abuse and rejection" (a position of more power). Although it is a painful realisation to make, it paves the way for constructing a problem narrative that provides Mandy with a clear and operational path to a solution.

5.5 THERAPIST AND CLIENT AS FACTORS vs. THERAPIST AND CLIENT AS PERSONS

Since the 'space between' is utilised for critical reflection on various factors that inform the problem narrative, the client and therapist themselves are often the factors that need to be reflected on in the space between. It is useful then to distinguish between the therapist and client as individuals versus therapist and client as factors for reflection. This distinction allows for a person to be in a dynamic relationship with the self while maintaining a reflexive distance to observe the outcomes of this relationship with the self.

For example, the therapist, following from Mandy's emotional reaction mentioned above, taps into therapist factors of empathy and understanding but resists saving Mandy from her own condemnation. Instead he invites her to reflect on her intense emotion and self-condemnation (client factors) in the space between:

I can see that this realisation is very painful for you to admit. I'm trying to make sense of why any person would make herself available for such abuse in

the first place and an image keeps popping into my head, an image of you being two people at the same time. The one appears to be angry and disappointed at the other for something she did and now is punishing her for these deeds. I don't know why I am thinking of this, but tell me what you make of that image?

By placing his imagined thought content (therapist factor) in the space between, the therapist again brings a different explanatory narrative to the space between, one that can account for Mandy's self-damnation. By proposing the image of her as two distinct individuals, the therapist can invite the client to externalise these self-objects in the space between and empathically and critically reflect on both their sides of the story. Through reflexive engagement on this image the therapist and Mandy together constructed the narrative of an older self-object being critical and disapproving of a child self-object without having any empathy for what the child self-object experienced all on her own without any adult guidance.

The therapist here made use of theoretical explanations (a model/technique factor) to legitimate this narrative:

From a psychodynamic framework I often see clients who experience different parts of themselves being in conflict with each other. It is almost as if these different selves represent them at different ages in their lifespan. Thus an adult self can look at what the child self did back then and feel angry, whilst the child self can feel misunderstood by the adult self, thereby alienating them from each other. It is often times helpful for these different selves to develop empathy and understanding for each other's viewpoints. Would you be willing to explore ways of how we can assist these different parts to accomplish that?

Here the client herself (or at least different parts of her) is being externalised and reflected on as a factor in the therapeutic process. This means that the client simultaneously holds the position of subject (i.e. a human person with reflexive capability) as well as object for reflection, that is two distinct self-objects that are in relation with each other). The next chapter offers an in-depth case study to fully explain this technique.

5.6 MODEL/TECHNIQUE FACTORS

In the case of Mandy, an object relations model was used as a potential explanatory framework to supplement her rigid problem narrative. However, within the framework of this model, it is possible to utilise different theoretical models and techniques as factors to be reflected on in the space between. The model or technique then is not merely a guiding force for the therapist, but becomes part of the evolving problem narrative that eventually suggests possible paths to a satisfactory solution.

For instance, it was discovered that Marcus who was struggling with a sense of apathy and nihilistic depression has had a long history of being very hard on himself when it came to personal expectations. As a child he was keenly aware that they, as a family, were poor and he developed a sense of personal inadequacy as a result. He was also aware of how his parents tended to approve quite easily with anything that he did, and thus developed the idea that they were prone to approve of mediocrity, especially since in Marcus' mind they never appeared to do anything to uplift themselves out of what he perceived to be poverty.

Now as an adult, Marcus avoids spending time with his parents, readily admitting that he feels ashamed of them, and moreover feels pressure to uphold an image of superior masculinity and success among his friends. Although he is aware that his friends' perceptions of him as a lady's man are far from true, Marcus admits that he cringes at the thought of admitting that he is quite humanly flawed in his capabilities.

After these distorted thought patterns were 'discovered', the therapist made the following remarks to Marcus:

> *I cannot help but notice that you appear to have exceptionally high standards, not only of yourself, but also of your parents. Now I am wondering whether these standards extends to other people as well, or do they only hold for those people you consider as part, or representative of you?*

After much exploration on this topic, consensus was reached that Marcus' exceptional standards were aimed primarily at himself and at his parents as an extension of himself. Moreover, the problem narrative was expanded to include his anxieties of being perceived as poor and inadequate:

> *How do you think your childhood experiences of poverty [client factor] impact on your current high expectations of yourself [client factor]? I am specifically thinking [therapist factor] about your view of how your parents dealt with poverty [client factor] and what lessons you learnt [client factor] from them about dealing with personal poverty?*

This question invites a reflexive dialogue on how past experiences may have formed core beliefs on how to deal with personal inadequacies. Marcus' response suggested that he learnt as a child that he needed to do things differently from his parents should he want to achieve success.

Since his parents were so easily accepting of poverty and mediocrity, he developed an extremely critical rejection of any signs of personal inadequacy, weakness and by extension

humanness. Upon reaching this problem narrative, the therapist made the following comment to Marcus:

> *From our exploration of your thinking patterns around weakness, it strikes me [therapist factor] that you have constructed yourself exactly opposite your parents, and this distorted idea of them leaves me with the uneasy feeling [therapist factor] that they weren't very good people. Is that an accurate perception?*

Here the therapist engages various therapist factors (personal feelings, images, etc.) to invite the client to consider the value judgments in his own representation of his parents as 'bad people'. The therapist here utilises the cognitive behavioural concept of black/white thinking to facilitate a reflexive dialogue in Marcus' distorted cognitive schema of his parents.

By being confronted with the suggestion that his parents are purely bad, it indirectly activates thoughts of what good qualities they may possess. Marcus immediately defends his parents by pointing out how welcoming they have always been, how emotionally supportive they are and how they always managed to make most situations fun.

By reflecting on these qualities in the space between, the therapist opts to adopt a specific role (that of devil's advocate = therapist/technique factor) to amplify Marcus' identification with the good qualities his parents possess before engaging him in reflecting on how his cognitive distortions regarding himself and his parents are linked to his complaints of apathy and nihilism:

> *Interestingly, although my impression of your parents [therapist factor] have not been favourable, given all the bad you have told me about them [client*

factor], I cannot help but notice something else. I am well aware of the fact that people in your position often engage in a psychological error known as black and white thinking [technique factor], where they identify with only the good or the bad in a particular situation. In your case it seems like you have associated your parents with all the bad at least when it comes to success, and as a result you've forgotten about all the good that they bring to your life. What is interesting to me, is that all the good they bring to your life, the emotional support, fun and welcoming nature are seemingly the things that you complained are missing from your life at the start of our sessions. If I recall correctly, you complain about not feeling much or caring about much, that you find no enjoyment in anything or see no meaning in anything. Given this coincidence, it makes me wonder whether your distorted view of your parents hasn't led you to cut out the bad together with the good they bring to your identity, leaving you with a strong looking shell of an identity that currently contains no substance or meaning. These are overwhelming thoughts for me to sit with, so I am eager to hear your thoughts on the matter?

By bringing cognitive behavioural concepts into the space between, the therapist invites Marcus to engage with this model as an explanatory framework for his problem where seemingly unrelated life events are now being tied together in a causal relationship. It also paves the way for Marcus later using techniques and ideas in the model to correct his distorted ideas of himself and his parents, thereby connecting with the human and flawed side of himself without experiencing the anxiety of being a failure for doing so.

Again it should be pointed out that the therapist reveals much of his own opinions, thoughts and theories [all therapist factors] in the space between, but never imposes them

unilaterally on the client. The client is let in on what the therapist is thinking, but these thoughts are presented as having a life of their own, appearing spontaneously in reaction to what the client says. Of course, the client should then also have the opportunity to respond and have an opinion on these thoughts. It is exactly these differing ideas and opinions that spark the perturbation of old and rigid ideas and is such a potent facilitating force in the co-construction of a new problem narrative.

5.7 TECHNIQUE SLOT

Apart from the 'space between' where reflexive dialogue takes place, this social constructionist model of therapeutic factors also contains what is called the 'technique slot'. As explained in more detail in Chapter 4, the technique slot denotes a process where the therapist employs a specific psychotherapy technique with some therapeutic goal in mind. Given that the technique slot is unidirectional, it indicates that a technique is performed on the client by the therapist without necessarily engaging in critical reflection, although it is often very helpful to reflexively consider the outcomes of techniques in the space between.

As an example, Zanele, during her admission to a local psychiatric clinic had been experiencing intense panic attacks that were related to previously repressed memories of her being molested as a child. While the overall therapeutic process was focussed on co-constructing a new problem narrative of Zanele learning to delegate responsibility and learning to trust in significant others, her intense anxiety made it difficult to focus on this therapeutic goal.

In an attempt to contain Zanele's anxiety, the therapist introduced Zanele to the technique of EMDR which was performed over several days in hospital. In conjunction with EMDR, Zanele was also taught to perform several relaxation techniques including guided

relaxation and systematic breathing techniques. Through her mastery of these techniques Zanele's panic attacks eventually subsided. This allowed for a reflexive dialogue between her and the therapist regarding her experience and the outcome of these techniques. Specifically, Zanele found these techniques to be quite empowering especially since she was currently feeling quite alone and questioning the degree to which she could rely on significant others.

Furthermore, during the course of the EMDR it was revealed that much of Zanele's anxiety was related not so much to the sexual abuse itself, but to her concern over how significant others might change their opinions of her if they found out. Another concern of hers was whether significant others, including her mother, knew about the sexual abuse but chose to ignore it. These revelations that surfaced through the employment of a technique add valuable information that can shape the client's problem narrative given that it is reflexively discussed in the space between.

By reflecting on these outcomes of EMDR (technique factors) in the space between, the therapist and Zanele managed to expand the problem narrative to include her sexual abuse as another area in her life where others unintentionally failed her, instead of Zanele carrying the responsibility for these incidents all on her own. The new problem narrative made solutions to her problems very clear: Hand the responsibilities of others back to them. This included confiding in her mother about her sexual abuse and her feeling that she should have been protected by her mother. By opening up to her mother in this way, they were able to clear the air in their relationship and Zanele was able to open up and rely on her mother without residual fears relating to unresolved past events.

5.8 THERAPEUTIC SUPRA-SYSTEM AS A FACTOR

At the conclusion of a therapeutic process, it is standard practice to terminate therapy by reflecting on the overall process of psychotherapy as a means to summarise what the client has taken from the process. On the other hand, it is often a crucial part of the therapeutic process at any given point to reflect on the process as a whole. This then means that the whole therapeutic system takes centre stage in the space between so as to affect the co-evolving problem narrative.

In the case of Heinrich, it was often necessary to reflect on the therapeutic supra-system as a factor that affected the problem narrative. Since there were many issues to focus on in his therapy process, Heinrich was often resistant when the therapist commented on his tendency to be evasive when defining himself as an individual, especially in terms of his sexuality. "What does that have to do with anything?" is often a retort that would come from Heinrich's mouth.

Given that therapeutic success, in the context of this model, is dependent on expanding the client's problem narrative, it is crucial to link several of the therapeutic factors together to form an explanatory frame that is less restrictive than the original problem narrative. In Heinrich's case, his sexuality was a key component that prevented him from making meaningful connections with others and was thus indirectly linked to his suicide attempt. In reply to his dismissive retort, the therapist would reflect back on his experience of the overall therapeutic process:

> *It seems that it is hard for you to commit to defining yourself in my presence [therapist reflecting on self as a person]? I say this because my experience of our time together has been that my attempts to get to know you on a more intimate/personal level is met with evasiveness followed by you shutting down completely [therapeutic relationship as a factor]. So I gather that this type of*

situation [referring to the interactional situation as a whole] is quite uncomfortable for you? Do you find that the way I ask you [therapist factor] about yourself makes you want to isolate yourself from me? Also I'm wondering whether you find similar difficulties in other social situations.

Here the therapist links the issue of isolation with his experience of the therapeutic supra-system as a whole and invites the client to reflect on his experience of the supra-system as a whole. The conversation that unfolds then clearly has implications for the problem narrative as it relates to the client's avoidance of defining himself in social situations.

5.9 CONCLUSION

While this chapter focusses on illustrating the social constructionist model of therapeutic factors' operational application by way of case illustrations, the next chapter will focusses on giving an example of an in-depth case formulation.

Chapter 6

EXTENDED CASE FORMULATION

Whereas Chapter 5 focussed on highlighting key elements of the social constructionist model of therapeutic factors with the help of practical illustrations from clinical case studies, the current chapter focusses on providing an example of how the model can be utilised by clinicians in an extensive case formulation. The case of Lindie[14] was selected for this purpose due to the clarity with which it highlights the practical strengths of the model.

6.1 ALONG CAME A SPIDER: LINDIE'S ANXIETY

Lindie is a 33 year old female who lives on her own in Johannesburg. She was married for three months and divorced in 2007 due to having been physically abused by her husband. She has no children or dependents. She works in the legal field and has Honours degrees in Criminology and Psychology. She describes herself as being religious and is an active member of the Presbyterian Church. A full clinical interview formed part of the first session to gather information regarding various aspects of Lindie's functioning.[15]

6.1.1 Main Complaints

Lindie first consulted the clinic[16] late in 2013. During her intake session, she described her reason for seeking psychotherapy as stemming from a desire to "deal with past issues" that

[14] The client's name and other personal information were changed to protect her anonymity.

[15] In the model presented here, the act of gathering clinical and personal information sets a context characterised by purposeful exploration, as if communicating to the client that the therapist is gathering data with a specific goal in mind. As such, the therapist engages in the act of information gathering with the awareness of its strategic value in shaping the therapeutic interaction at a later stage.

[16] Sandton Psychology Centre

affect her choice of partners and friends. Specific complaints raised by Lindie included nightmares of her being rejected in past friendships and relationships. These nightmares preoccupied her thoughts and had a debilitating effect on her mood and general functioning for a few days following their occurrence.

A second major complaint that Lindie wished to address, was her fear of spiders. She stated: "I have a phobia of spiders" and described how she was preoccupied with this fear to the extent that she tried to avoid any situation where she might be confronted with a real spider. Lindie reports having had numerous panic attacks when seeing a spider. Even coming across an image of a spider on Facebook led her to become extremely anxious, hyper vigilant and preoccupied with fear.

Lindie reported that her fear of spiders impacted negatively on her daily functioning as her avoidance of situations where she might come across a spider limited her productivity at work and at home.

6.1.2 History of Main Complaints

Although Lindie was always somewhat fearful and cautious of spiders, she first started experiencing an excessive fear of spiders 10 years ago. Her first intensely fearful reaction to spiders developed in a context where she was living in a townhouse on her own in an area where she was confronted with rain spiders on a daily basis. As this was the first time she ever lived alone, Lindie was confronted with the reality of dealing with these spiders by herself since there was no one else to rely on for assistance. The idea of dealing with spiders on her own made her extremely fearful and avoidant of them. Her fears of spiders recently became unbearable for no reason that was discernible to Lindie.

6.1.3 Medical and Psychiatric History

Lindie reports no history of significant general medical conditions that may affect her current functioning. This was her first contact with a mental healthcare professional. She was not taking any medications during the time of the therapeutic process.

6.1.4 Substance History

Lindie reports no history of substance use, abuse or dependence, including cigarettes and alcohol.

6.1.5 Family History

Lindie is the younger of two children. Her sister Danel is two years older than her. She reports that her family was characterised by a conflicted, resentful and distanced relationship between her mother and father. According to Lindie, her mother was very bitter and resentful towards her father for not providing enough and blamed him for their poverty. She also remembers that her parents never had any physical contact and lacked intimacy.

Lindie reports that she had a very close relationship with her father as a child. However, her father died of a heart attack at the age of 42 years, when she was nine years old. After her father's death, Lindie's mother prohibited them from speaking, or asking any questions, about him. Her mother also became verbally abusive towards Lindie, insulting her by calling her "ugly and stupid". Her mother's judgmental attitude towards Lindie left her "feeling rejected and neglected" by her mother. She also reports that her mother admitted to her at times that she did not love her.

Lindie describes her relationship with her sister to be emotionally distanced, as her sister has always been very close to her mother. Lindie also perceived her sister to receive preferential treatment from their mother. As a result of what she endured at home, Lindie reports that she used to avoid being home at all costs, preferring to spend her time at her friends' houses whose families she admired and envied.

At present Lindie reports to have no contact with her mother or sister. She states that she has negative feelings towards her mother, and prefers not to have contact with her due to her verbally abusive nature.

6.1.6 Peronal History

Lindie reports that she was born via Caesarean-section and is not aware that her mother experienced any complications with her pregnancy or giving birth. She is unsure whether she was a planned pregnancy, but reports that since she can remember, she never really felt like an appreciated part of her family. She describes herself as having been a difficult child, as she was allergic to dairy and hence was a big burden on her mother. When she was somewhat older, Lindie remembers that she was quite shy but very inquisitive and had many friends.

She started attending school at age six years and recounts that she loved every moment of school, despite her having been the target of bullies who made fun of her for being a "nerd". Lindie reports that she wanted to spend as much time at school as she could, since she felt a sense of belonging there. She managed to complete school without any major obstacles.

With regards to her relational history, Lindie reports that she, as a teenager, always had a boyfriend. Her first relationship started when she was in grade 10 and ended two years later at her Matriculation farewell when she broke up with her boyfriend for not ever having stood up for her when her mother insulted her. Lindie reports that her first relationship was

characterised by her mother comparing her (Lindie) to him (Lindie's boyfriend) who used to buy her mother expensive and extravagant gifts. Lindie reports that her boyfriend's and mother's behaviour made her doubt her own worth and she experienced the expectation that she needed to work harder to gain the same acceptance from her mother as her boyfriend experienced from her mother. Since her first break up, Lindie reports that she started to question her own worth and felt especially critical of herself when she was not in a relationship.

Lindie married in 2007. It was not long thereafter that her husband started to become physically and verbally abusive towards her. They divorced three months after the marriage. In 2012 Lindie moved from her home in Pretoria to Kwa-Zulu Natal after she became engaged to her boyfriend at the time. They lived together for one year, but terminated the engagement after this fiancé also became abusive towards Lindie. In mid-2013 Lindie moved to Johannesburg where she is currently working and living on her own.

6.1.7 Current Stressors

In sum, Lindie has experienced the following stressors that contribute to her current distress:

- An abusive relationship with her mother (i.e. victim of verbal abuse, rejection and neglect);
- A divorce in 2007 following three months of an abusive marriage;
- A move back to her home in Kwa-Zulu Natal in 2012 to live with her new fiancé, who then also became abusive;
- A relocation to Johannesburg in 2013 where she is living alone;
- At present she has no close friends and is suffering disappointments due to loss of close friendships;
- A lack of social and familial support.

6.1.8 Protective Factors

- She is well educated, friendly, optimistic, young and attractive;
- She has a stable- and well-paying job;
- She is committed to, and active in, religious practices (Christianity);
- She has supportive colleagues.

6.1.9 Initial Considerations Related to the Problem and Plan for Treatment

It was initially considered by the therapist that Lindie qualified for a diagnosis of a specific phobia with situationally precipitated panic attacks. In addition she appeared to experience adjustment issues related to the numerous stressful life circumstances she had to endure. This may be accounted for by an *adjustment disorder with anxiety* or a V-code of *problems related to primary support group*.

Although these diagnoses can clearly be qualified from her clinical history, the danger exists that important factors may be overlooked when such a simple, reductionist understanding of her seemingly unrelated problems is embraced uncritically. For example, the diagnosis of a specific phobia may lead to the conclusion that Lindie may benefit best from a cognitive behavioural intervention such as In-vivo exposure therapy or eye movement desensitization and reprocessing (EMDR) therapy. After all, from the view of evidence-based approaches, such techniques enjoy vast empirical support for their effectiveness for specific phobias. Furthermore, as a means to address her social concerns, one could recommend social skills training, interpersonal therapy or any of the other range of empirically validated treatments for such social problems.

However, from the information provided by Lindie during the clinical intake, the therapist noticed certain coincidences in her history that prompted him to devise several hypotheses to be reflected on with the client.

First, it seemed that Lindie has led somewhat of an isolated existence, left by others to fend for herself. This feeling of isolation was emphatically evident in her confrontation with spiders, when she first started living on her own. Maybe, then the fear was not so much of the spiders, but of dealing with them on her own?

Second, it seems that Lindie has suffered a long history of disappointments in people who were supposed to protect, nurture and console her in her times of vulnerability. These people who were supposed to accept her for who she is and encourage her to express her needs, wants and concerns rather judged and rejected her when she was being herself. As a result, Lindie reported having felt the expectation to "work harder for acceptance". Maybe then, observing how others rejected and neglected her when she was being herself, made her to be critical and judgmental of this authentic self?

Finally, if she has in fact become critical and judgmental of whoever this authentic self-inside of her is, then what has this done to her relationship with this self-inside of her? Is she able to trust this self to make the right decisions? Will this self be able to effectively confront and exterminate threats that seek to spoil Lindie's happiness or has she abandoned her alignment with this self? After all, is it not the fault of this authentic self and her 'deficiencies' that Lindie was deprived of a loving and nurturing mother? Maybe then, it would be unrealistic to expect Lindie to trust, love and care for this self, when she may be resentful towards this self for being the root cause of her rejection and neglect.

By considering these hypotheses, the therapist directed his information gathering to test his hypotheses and importantly to develop a personal narrative and comprehensive worldview

of the client's problem. This worldview is vital as it needs to incorporate not only what the client brings, but also needs to be sufficiently different from the client's worldview so as to leave room for both therapist and client to negotiate on a shared worldview of the problem. Since it is usually accepted that the client's worldview of the problem is 'problem saturated', the difference of the therapist's worldview should ideally present an explanation with unsaturated paths to a solution[17].

6.1.10 Formulation of the Problem

Following from the above questions and resulting hypotheses, the therapist delivered the following account to Lindie about his own worldview of the problem:

> *From what you told me about your problem today, there is no doubt in my mind that you are dealing with a phobia for spiders. However, what interests me more than the phobia, is your struggle with gaining acceptance and love from others. The whole time I thought to myself how this might be related to your fear of spiders, and then it became clear when I heard you say that you felt the expectation to work harder to gain your mother's acceptance. Could it be, that when she was small, you saw how your mother treated Lindie, and thought to yourself: 'There must be something wrong with me or with what I am doing for my mother not to be able to love me'. Maybe you even went so far as to think that small Lindie needed to be more than she was or work harder than she did to gain your mother's acceptance. So I wonder if your mother's judgments,*

[17] It is not always necessary or ideal for the therapist's worldview to suggest clearly defined solutions, as it is sometimes a useful approach to forge solutions in cooperation with the client. Thus, the therapist's worldview needs to be different enough to stimulate new ideas and/or questions that may eventually lead to new solutions.

insults and abuse towards small Lindie didn't make you to become critical of her as well.

After all, it appears that you lost out on having a loving mother, because small Lindie wasn't able to be more of what your mother expected. So in order for you to have hope of gaining some love and acceptance you aligned yourself with your mother's (and later others') critical and judgmental attitudes towards this authentic self-inside of you, you the small Lindie. Because you were critical of small Lindie, I think it must have been hard for you to maintain a good and trusting relationship with her. So it makes sense to me now why you were so terrified of spiders. If you do not feel close to the authentic self-inside of you, how can you be expected to trust her to confront threats from outside? I would like you to take a moment to reflect on what I have just told you about my views and whether or not it resonates with your experiences.

After being so candid in expressing his own worldview of Lindie's experiences, the therapist thought it was important to convey his understanding that this was his way of making sense of her problem and that Lindie was allowed to differ from him or to add to what he was thinking. In this way then, a space between them is created whereby they could assist each other to refine the meaning of her problematic experiences.

Lindie showed a strong non-verbal response while the therapist was delivering his account. Her eyes welled up with tears as she listened. Afterwards she remarked that his account touched on various experiences she had never thought about or was unable to verbalise, and that he assisted her to understand her predicament. However, she remarked that it felt

strange for her to think and speak of herself in relation to herself, and she was concerned that the therapist thought she had a 'split personality'.

At this point, the therapist reassured Lindie that this way of speaking of her as two people did not imply that she had a split personality, but rather stemed from personality theory (i.e. object relations theory and/or Kohut's self-psychology) and was meant to facilitate their reflecting on her relationship with herself. Here, theory and/or models of psychotherapy are discussed in the space between and by letting Lindie in on the theory, the therapist indirectly offered her the role of co-therapist, able to reflect on, and give inputs to, the explanation of her problem and the course of therapy. Regarding the latter, Lindie asked the obvious next question: "So what do we do about this?" This implies an acceptance of the role of co-therapist.

The therapist at this point felt the need to practice constraint, as he did not want to negate Lindie's newly established role as co-therapist by dictating the course of events. On the other hand it was also important not to project an image of uncertainty, as he could not expect Lindie to accept this partnership when it seemed as if he did not know what he was doing. The therapist therefore suggested to Lindie that he thought it was important to the process of therapy for her to consider the implications of what he suggested to her and also to think of what she needed to do about small Lindie in order for her to come to a place where she was ready to repair the relationship.

The latter response by the therapist achieved two things: First, it suggested a path or goal for psychotherapy (i.e. the reparation of Lindie's relationship with the self-inside of her); and second, it confirmed Lindie's role of co-therapist in that it accepted her as being the expert on what she needed to do in order to achieve the suggested goal of therapy.

This marked the end of the intake session. To summarise, the first session commenced with basic information gathering. It allowed the client to give an account of her worldview, and

allowed the therapist to sample the client's life experiences and form and test hypotheses that developed into a worldview of the client's problem. The first session was also used to set a precedent in terms of the therapeutic relationship and how the client and therapist used the 'space between'. In other words, the nature of their interactions determined the roles each adopted in the therapeutic process (e.g. expert vs leek, co-therapists, supporter and supported), and according to these roles, how the interactive space between them will be utilised to shape the co-evolving, co-constructed worldview of the problem.

6.2 FOLLOW-UP SESSIONS

Lindie's medical aid only covered a total of six sessions for psychotherapy. She attended four follow-up sessions before the therapeutic process was terminated.

6.2.1 Discovering the Self in the Attic

In her first follow-up session, Lindie reported that she was doing better since we first met. She made certain decisions to better her life and well-being. These decisions included joining a gym and finding a new church to attend. She also reported that she was sleeping much better and reported no nightmares in the past week. Although she was still experiencing anxiety in relation to spiders and her interpersonal difficulties, they were less intrusive and she was able to think of these matters without being overwhelmed by anxiety. These changes made her feel more empowered, according to Lindie's report.

The therapist reacted to Lindie's report by reflecting with her as to the origin of these changes in her condition. Lindie felt that it had to do with the intake session and the letter she wrote to the self-inside of her. In this letter she expressed several angry feelings relating to the

notion that the self-inside of her had been oppressed for so long and that her main focus was on pleasing others at her own expense.

When her letter and her experiences of writing were reflected on in the space between, Lindie acknowledged that she was surprised at the anger she was feeling when engaging in the activity. She was, however, not sure whose anger it was, as she still had difficulties distinguishing between herself as a critical observing self and herself as an oppressed authentic self. The remainder of the session focussed on critically reflecting on the anger and the relationship between the two selves as a means to further refine this co-constructed narrative of two selves driven apart and at war with each other.

The therapist, adopting a curious stance, asked various reflexive questions such as "As you are sitting with me here discussing your experiences of writing the letter, whose anger do you feel it is, yours or the self that have been oppressed", then "whom do you feel this self is angry towards?" and later "If she is angry of being oppressed, who is the one that oppressed her and maintains her oppression?".

Lindie found it quite difficult to give clear and specific answers to these questions. Her uncertainty was then reflected on in the space between, and the therapist suggested that it might mean she needs more time to explore these feelings given the questions that unfolded during their discussion and reflection together. The therapist, reflecting on his own experiences of the session, also made the remark that it appeared to him that, regardless of the underlying motivations, there is a self-inside of her (authentic self-object) who experiences intense and unverbalised anger that is likely directed at another self (critical self-object) and that her avoidance of confronting these resentments is maintaining a split in their ranks, leading to mistrust in herself. The therapist suggested that Lindie allow this oppressed self with the

freedom to express her anger and also to consider what affirmative action she required from her critical self in order to feel compensated for the injustices she had to endure.

The co-evolving narrative of two selves at war, suggest that the internalised parts of the self (i.e. self-objects) have complex, yet unacknowledged feelings towards each other. This evokes the idea of two persons who have strong feelings of love towards each other, but due to ineffective communication and misunderstanding have started to resent each other for not affirming their love for each other. This developing narrative allows for the construction of a worldview where Lindie as the person attending therapy can assume the role of peace facilitator in collaboration with the therapist. As such, the space between is utilised to reflect on the client as factor in this peace-making process in order to reach conclusions of what the necessary steps are to resolve the internal war.

The description of the client's experiences of the self as two distinct people allows her as a person to reflect on her experiences of herself as a factor from a neutral, 'objective' place. The goals of therapy also become progressively more defined (i.e. as re-establishing empathy and trust between an oppressed self and a critical self that were turned against each other, and as a result represents a disunited front against the challenges of the world).

6.2.2 Chipping through the Anger that Separates

During the second follow-up session, Lindie reported that she was doing very well. She felt increasingly in control of her anxiety and also became increasingly directive in her role as facilitator of peace within herself. She acknowledged that she found it very difficult to consider what affirmative action the oppressed self-inside of her required. One of the ideas she had, was to write a letter to the people who had wronged her in her past by making her doubt herself. This signalled to the therapist that the client was invested in the narrative that external agents

managed to divide her ranks by turning her ‘self’ against her ‘self’, thereby causing mistrust and doubt in herself.

As she was very vocal and expressed many opinions on the matter, the therapist utilised the technique of listening (and remaining silent) to allow the client to express the many ideas she had formulated over the past week. By doing this, the therapist allowed the client space to act out her role as facilitator and expert and gain confidence in being reflexive and critical of the status quo.

In her report of her ideas, Lindie mentioned that she had taken up the practice of conversing with the self-inside of her regarding this self-doubt. In this way, she reassures this self that she is worthy and should not allow others to walk over her. After Lindie seemed to be satisfied that she had expressed everything that she had thought about, the therapist commenced with reflecting on what had just happened in the space between. He did this by first reflecting on his experience and wonderment at what was going on today: “While I was listening to you, it struck me that you seemed to have a lot to say today and I became puzzled by your excitement. Would you mind enlightening me as to what led to this?”

With his remark, the therapist drew attention to the possibility that something significant might be going on that is not being verbalised and invited Lindie to critically reflect on herself and her excitement critically as it pertained to their worldview of the problem. Lindie, at first seemed to be perplexed at the therapist’s question, and stated that she did not know how to answer his question because she had not thought about it. The therapist then remarked that he was impressed with how she seemed to have embraced her role as peace-maker and especially of how she appeared to have commiserated with the oppressed self-inside of her by being quite nurturing and reassuring towards her.

The therapist then extended this reflection by asking the reflexive question: "When you were telling me about how you started conversing with her internally, I kept wondering how this oppressed self-inside of you must have experienced this interaction, especially since there have been years of angry silence between the two of you. Do you have any ideas on that?"

The conversation then focussed on exploring Lindie's oppressed self's needs for care, love, reassurance, etcetera, that she never received from the significant adults in her life and how Lindie built up walls to defend this self against getting hurt. The therapist, at some point during this discussion, remarked that the image of a big sister-little sister kept popping into his head. He also asked Lindie if they could give this self-inside of her a name to acknowledge her importance and to ease reference towards her. She decided that her oppressed self should be called *Megan* due to the childhood significance she attached to the name.

The therapist said:

> *When we speak of your relationship with Megan in this way, it reminds me of the type of relationship between a big sister and a little sister. The one is vulnerable and in need of care and protection, while the bigger one [therapist pointing to Lindie] is quite responsible and sensible. All this time I thought the two of you were just angry and spiteful towards each other, but it becomes increasingly apparent to me that deep down there is a lot of love for each other. Perhaps the two of you just misunderstand each other in terms of how you show your love.*

The therapist continuing:

For instance, [therapist pointing to Lindie] I now understand that when you saw Megan being insulted and rejected by your mother, you tried to protect her by shielding her from your mother's attacks and over time started to hide her from the world. In your attempts to protect her, it is also clear that you had to sacrifice many of your own needs in order to worry about protecting and hiding away your vulnerable little sister. So it is clear to me why both of you would feel angry. You Lindie, because you had to sacrifice your happiness by focussing on hiding Megan from the world, and Megan for misunderstanding your attempts to protect her as attempts to oppress her.

Lindie reacted to the therapist's comment by becoming quite tearful. Afterwards he asked her about her tears and what they meant. Lindie replied that they were an expression of relief as she was finally able to empathise with the hurt Megan felt and that it felt good that it was being acknowledged in the therapeutic conversation.

The therapist signalled the end of the session by reflecting on his idea that others seem to have convinced Lindie to believe that Megan is weak, fragile and will always be in need of care. He wondered whether this was truly the case, and whether it might not have been a good idea for Lindie to start giving Megan some freedom to be herself and to prove that she has many good qualities as a grown-up self that may even benefit and support Lindie in dealing with the challenges of the world.

By making this suggestion, the therapist suggested that through the liberation of her oppressed, authentic self, Lindie would be free from worry as she would be able to embrace

herself fully without worrying about the judgements of others. In this way then, Lindie could start to trust in Megan and count on her to have her back when faced with the challenges of the world. They no longer had to be split in their ranks by personal judgements that stemmed from the judgements of others.

6.2.3 Enjoying the Fruits of Liberty

In her third follow-up session, Lindie reported that her anxiety had almost entirely subsided. During the past week, she was exposed to pictures of spiders which led her to experience some manageable level of anxiety, but was pleased to say that she did not become overwhelmed with debilitating fear. From her report of her past week, it also became evident that she started experimenting with not being so controlling of Megan.

When reflecting on the effects of her experiment, Lindie reported that she had not felt as defensive in the past week when relating to other people. In fact, she approached her colleagues and acquaintances in a more carefree, spontaneous manner and smiled broadly as she stated that she started to feel like her old self for a change. It appeared from her behaviour and general demeanour as if Lindie felt a sense of relief, and the therapist relayed his subjective observation in the space between: "You appear to be relieved today? If this is true, of what have you been relieved?" The therapist hypothesised that Lindie's relief stemmed from the fact that she was no longer monitoring her every move, but was learning to embrace and trust in her unique, authentic self's worthiness.

Lindie, replied to his question by admitting that she had realised with increasing clarity that she had built a wall around herself by overthinking her relationships and doubting herself. As a result of trying to analyse the right way to behave in relation to others, she had kept people at a distance, afraid that they might see and judge the vulnerable, weak self-inside of her. The

more Lindie got to know and like this self, the less she had to worry that others would judge this self and the more energy she had to be spontaneously herself.

Another positive development Lindie was pleased to share, was that she was able to let go of her preoccupying need to be in a relationship. No longer did she feel the need to have someone in her life in order to survive the challenges of the world. When the right man eventually crosses her path, she would be ready, but definitely not desperately waiting in anticipative anxiety.

The therapist really enjoyed this third session, as he did not have to do very much 'work'. It was apparent to him that their co-constructed new narrative had taken root and transformed Lindie's worldview of the problem. She had a satisfactory explanation of why she was anxious and this explanation stimulated her to devise many of her own solutions to her problems. The therapist was able to sit back and enjoy Lindie's delight at exploring her newly recovered sense of empowerment and personal agency. He did of course, throw in the odd reflexive question and/or statement as a means to support Lindie's new found agency.

Statements such as: "What amazes me is how much more in control you seem to be, especially since it was a big fear of yours to give up control." This statement merely encourages the client to be reflexive and appreciate the significance of what she had achieved. It often occurs that clients tend to underestimate the magnitude of the changes they have made, chiefly because these changes occurred in the flow of things and were not consciously reflected on. The therapist's continued use of a reflexive stance also reinforced the value of such a stance, not just when things were going badly, but also when things were going well.

The fourth follow-up session was scheduled with the understanding that it would be used to reflect back on the therapeutic process and to tie up any loose ends that may still be dangling in the air.

6.2.4 Looking to the Future by Looking Back

With the fourth follow-up session, Lindie reported nil debilitating anxiety. During the week her cat had walked away, which saddened her immensely. Instead of being afraid of, and suppressing these feelings, Lindie said she tried to embrace them and to express her feelings of sadness to others. To her amazement, she found people to be generally supportive instead of judgmental towards her.

The session further focussed on reflexively discussing the therapeutic process as a factor in her improvement. The idea was to place Lindie's improvement into context by reflecting on what exactly had changed, how it had changed, who had changed it, what supported this change, and what prevented this change in the first place. Reflexive questions such as: "How would you explain what helped you to make the brave changes you made to better your life?", and "If you were to face a similar challenge in future, what would you take from what you achieved here in order to help you then?".

These questions, first reinforce the idea that the client was the main agent of change by suggesting that all other factors were tools at her disposal, and second they suggest a reframe of the idea of relapse, not as something to be feared, but as a challenge that could resurface and that could be managed by the client if she adopted a similar reflexive attitude in using the tools available to her in order to find a satisfactory solution.

The therapist and the therapeutic process as factors are of course included in this reflection. The value that these factors played in the client's path to wellbeing should be reflected on as well, not so much for the sake of credit, but rather as a means to help the client articulate the benefits of the process. This type of reflection helps to demystify the process of psychotherapy and by proxy also the nature of psychological problems.

For instance, in Lindie's case, reflecting on the value of psychotherapy helped us to define the process as one of critically taking stock of her past experiences and the implications they had for her relationship with herself. Defining it in this way then gives the process of psychotherapy a clear purpose and served to empower Lindie by suggesting that her problem was never some mysterious disorder that should be cured by magical techniques, but rather stemmed from her accepting others' judgments uncritically.

Therefore, in future, should she experience problems again, they need not be a cause for concern, all she will need to do is to take critical stock of her assumptions about her relationship with herself and her relationships with others, And if she should need to see a therapist to help her to do this, then so be it. The idea is that she walks away with the belief that her problems can be managed by maintaining a united and trusting relationship with the self-inside of her and that this internal unity gives her the power to manage and solve any challenges thrown her way.

6.3 CONCLUSION

In this chapter an extensive and detailed case formulation used the social constructionist model of therapeutic factors. Lindie's case was used to illustrate how the model serves to guide a therapist and client through a meta-reflexive process of the various factors that feed into an existing problem narrative. It also illustrated how reflexivity on therapeutic factors can be used to co-construct a new problem narrative that includes potential and viable solutions. The next chapter concludes with a critical reflection on the model in terms of areas of application as well as its contributions and opportunities for refinement through further research.

CHAPTER 7

DISCUSSION AND CONCLUSION

In the foregoing chapters various aspects of the evidence-based approaches to psychotherapy, including empirically supported treatments (EST's) and evidence based practice (EBPP), are considered. Of specific interest were the philosophical assumptions of these approaches, and although many differences were highlighted between EST's and EBPP, the discussion in Chapter 2 revealed that both approaches are firmly based in a positivist epistemology. As a result, a tendency has developed among evidence-based proponents to favour the empirical method of scientific enquiry over other scientific methods of enquiry and in some extreme cases even singles out empiricism as being the only legitimate method of enquiry (see Chapter 2).

As an antithesis to the evidence-based approaches, the Common Factors model of psychotherapy offers convincing arguments, backed by substantial empirical evidence to support its opposing view (i.e. that it is not model-specific factors), but common factors that best account for the effectiveness of psychotherapy. Despite its contributions, a critical discussion of the Common Factors model revealed that it too has serious limitations, the most limiting of which relate to its unequivocal adoption of a positivist epistemology and hence reliance on empirical evidence above other methods of enquiry.

The objections to the uncritical acceptance of positivist assumptions by the majority of the scientific community are not aimed at discrediting the contributions of empirical enquiry in psychotherapy. Rather the aim is to point out and question the tendency to marginalise other methods of scientific enquiry through adulating the empirical methods as the current trend seems to be. Examples of such dangers include restrictive and exclusionary health funding

policies and restrictive practice guidelines that are informed by philosophically biased assumptions about the nature of evidence in scientific research.

Chapter 3 focussed on providing a balanced view of scientific enquiry by elucidating an alternative worldview of reality and of scientific enquiry, one which critically accepts positivism as one of many possible and equally valid explanations of reality, and hence neither champions, nor rejects empirical enquiry. Rather, a social constructionist epistemology considers empiricism to be one of many useful approaches to gain scientific insights into the question of effectiveness of psychotherapy. Of further importance, are the potential contributions of a social constructionist epistemology to the field of therapeutic factors research that has not been fully appreciated as of yet.

An attempt to apply insights gained from an alternative epistemology to therapeutic factors research finds expression in the form of a social constructionist model of therapeutic factors that are discussed in depth in Chapter 4 and demonstrated practically through case studies in Chapter 5 and 6.

As the proposed social constructionist model of therapeutic factors attempts to address the shortcomings of EBPP and common factors models, it should offer something unique and useful in the arena of therapeutic outcome research. The rest of Chapter 7 is devoted to a discussion of the contributions of the proposed model and also examines opportunities for refining such a model.

7.1 CONTRIBUTIONS

Much of what is proposed in the social constructionist model of therapeutic factors reflects what therapists already do in therapy. Therefore the question may arise as to whether the model does not simply state the obvious.

On the surface the model appears to state the obvious in the sense that it endorses what many common factors models propose: that is what therapeutic factors are effective. In addition, however, models of therapeutic factors, including the model proposed here, also seek to explain *why* therapeutic actions are effective to lend scientific legitimacy to its claims of effectiveness. Hence, the proposed model is embedded in deconstructive analyses of specific theoretical assumptions that inform therapeutic actions as well as case illustrations to demonstrate the implementation of therapeutic actions.

As discussed in Chapter 4, an assumption of the social constructionist model of therapeutic factors is that change occurs chiefly as a result of two people, client and therapist, who engage collaboratively to construct a more useful worldview of the problem. In the case of Lindie (see Chapter 6), it was illustrated that the therapist, through hypothesising about the possible meanings of the therapeutic factors involved in the case of Lindie, tries to conceptualise an alternative worldview of her problem in order to give an alternative explanatory frame for her problematic experiences.

The therapist's worldview of the problem incorporated many of the experiences, discourses, narratives and metaphors that Lindie's account carried. However, the therapist's worldview was also quite different from Lindie's worldview. It incorporated Lindie's problem narrative, but also added to it by drawing from his training, knowledge of psychological theories/models, ability to imagine, describe, empathise by virtue of his personal experiences of relationships and disappointments and of being human and vulnerable.

The process of therapy (at least within this social constructionist model) relies heavily on the differences between clients' and therapists' worldviews to the extent that it invokes just enough, but not too much, uncertainty to stimulate critical reflection, in the client, of previously accepted assumptions about self and problem. The therapist, who uses this model seeks to utilise the uncertainty created in the client to co-construct a new and more useful narrative of the problem, one that can inspire different behavioural pathways that were not possible in the previously accepted narrative.

The example above illustrates that the proposed model gains scientific legitimacy through its theorist's ability to account for its assumptions and illustrate this practically. The legitimacy obtained through this process is no better than the empirical legitimacy obtained by EBPP and common factors models. Furthermore, it is important to recognise that all methods of legitimacy are themselves based on assumptions of reality and of what constitutes science.

In contrast to EBPP and common factors approaches, which seek to utilise methods of scientific legitimising to prove their universal superiority, the social constructionist model of therapeutic factors proposed here does not seek to establish its universal superiority. This is because its guiding epistemology rejects the very idea of contextually abstracted and universal truths. Given this worldview of multiple truths, it would be a fallacious goal to strive towards establishing a universally superior model of therapeutic factors.

Instead the idea of local truths and local utility are embraced. Hence the proposed model is based on the assumption that the usefulness and truthfulness of any therapeutic endeavour varies, and this variance is dependent on the relational context in which the therapist and client find themselves. Thus, a therapeutic endeavour's usefulness is determined in an interactive process between a specific client and a specific therapist in a specific interactional context. The proposed model of therapeutic factors is unique in that it does not view the effectiveness of

psychotherapy to reside in any one self-contained technique, model or therapeutic factor, but rather in how these models and factors gain their meaning as being useful only in relation to other factors and in relation to a specific therapeutic context. This alludes to the concept of performativity as described by Barad (2003) in her account of a relational ontology of bodies.

As a result, the social constructionist model of therapeutic factors rejects the claims, and even the pursuit, of universal superiority as espoused in EBPP and common factors models. On the other hand, the social constructionist model of therapeutic factors accepts the claims of legitimacy by EBPP and common factors models in that any of these approaches are likely to be deemed useful and truthful in specific interactional contexts with specific therapists and clients so long as these approaches offer some form of alternative worldview of the client's problem that leads to satisfactory paths to solutions.

As much as the social constructionist model of therapeutic factors draws from well-known social constructionist and eco-systemic concepts and critiques, it is also an attempt to express these concepts and critiques in a model that can be applied in clinical and research settings. Thus the model is unique in that it attempts to operationalise valuable eco-systemic and social constructionist insights that have so far remained largely on and abstract and critical plain.

As an operationalised model, the social constructionist model of therapeutic factors not only highlights the shortcomings of EBPP and common factors conceptualisations of effective therapy, but also offers alternative ways of conceptualising effectiveness in psychotherapy. The proposed model highlights the interactional and collaborative process in determining the usefulness of therapeutic factors, and also appreciates and incorporates important contributions made by both EBPP and common factors models.

As such, the proposed model draws from a substantial body of empirical information that is used to delineate groups of therapeutic factors thought to be common across various models of psychotherapy. However, the model also cautions that the usefulness of any of these factors cannot be guaranteed on a universal level. Similarly, the proposed model draws from the evidence based principle of selecting treatments and techniques that are likely to work in specific situations with specific problems. Most importantly, the model emphasises that specific techniques or treatments are to be utilised as supporting aids in the more crucial therapeutic activity of renegotiating a worldview of the client's problem that may inspire alternative and potentially more useful behavioural paths.

Therefore, rather than being an opposing view to EBPP and common factors approaches to therapeutic outcome research, the social constructionist model of therapeutic factors provides a larger framework in which both common factors and specific factors play crucial roles in affecting therapeutic outcomes. At the centre of this more encompassing frame of the therapeutic process is the notion of therapy as an interaction aimed at disrupting a problem-saturated narrative, rather than therapy as a unilateral performance of procedures applied by a therapist to a client.

7.2 CRITICAL REFLECTIONS

Given that the proposed model is based on contributions from eco-systemic and social constructionist theories, and also draws from empirical findings of the common factors and evidence based approaches, validating the approach should prove difficult from an epistemological standpoint. The principles of contextual sensitivity and/or flexibility, which are a central component of eco-systemic and social constructionist theories, make it difficult to standardize therapeutic approaches based on these theories. Also, from a social constructionist

viewpoint, it is accepted that truths and therapeutic outcomes are constructed locally and thus any desire to prove the model's general usefulness poses a philosophical dilemma.

Given that the onto-epistemological foundations on which the social constructionist model of therapeutic factors are based differs substantially from current positivistic values of empirical validation, the model does not lend itself to outcomes studies that seek to determine its overall validity and reliability as a method. In fact, the opposing nature of the ontologies of realism and relativism, which are at the core of the debate regarding evidence means that agreement in this field is improbable, unless a different viewpoint is considered.

Posthumanist, Karen Barad attributes this stalemate between realists and relativists (including social constructionists) to the uncritical acceptance of representationalist assumptions (as opposed to performative assumptions). According to Barad (2003):

> *…[realists and social constructionists] share representationalist assumptions that foster such endless debates: both scientific realists and social constructivists believe that scientific knowledge…mediates our access to the material world* (pp. 805-806).

Barad (2003) advocates that a performative understanding is needed to appreciate the reality of things, and criticises the tendency in scientific observation to think in terms of represented objects and their representations in language. Rather, she and many others, are of the opinion that a relational ontology better captures the complexities of reality as it acknowledges the material (including practices such as scientific practice) while rejecting representationalist notions of self-contained, static beings. Barad and others' ideas of a

relational ontology challenges the concept of scientific evidence, since such an ontology suggests that the gap, which occurs between an observed object and its representation, will always lead to the problem of having to account for observations. In a relational ontology, however, the observer and the observed are said to be simultaneously part of a relational performance, thereby being defined in relation to one another. This performative understanding then eliminates the gap between an observer and the observed that exist in a representationalist account. Barad's work may thus impact greatly on how evidence is defined in the field of therapeutic factors research as well as how we conceptualise our models of therapeutic factors.

The proposed model of therapeutic factors, for instance, is based on a social constructionist epistemology that assumes the existence of a therapist and a client who together give rise to a therapeutic relationship. Barad's (2003) ideas on a relational ontology, however, suggest that relationality is not dependent on the existence of independent *relata*. Taking these ideas into account may open up avenues to explore how the relational performance of therapy may give rise to, and define, what we currently observe as self-contained human entities (i.e. client and therapist). Future development of the model proposed may also gain valuable insights from the works of Butler (1993), Haraway (1992), Rouse (2002) and Slife (2004) among others.

7.3 OPPORTUNITIES FOR REFINEMENT AND FURTHER RESEARCH

Notwithstanding the critiques of the uncritical acceptance of empiricism, it is acknowledged throughout this thesis that there are important benefits of empirical research findings. Although efforts have been made to promote flexibility in clinical practice and decision-making, the proposed model is likely to benefit from refinement in this area. For instance, it would be interesting to research how the proposed model may be applied

appropriately in different professional settings, including research-, organisational-, clinical-, counselling- and assessment settings.

Given that varied professional settings set diverse demands on professionals, the model may be utilised differently in different contexts. In an organisational context, a professional may need to adjust the model when working with more than one individual at a time; or in counselling or clinic settings family and/or group therapy may be more warranted. This may require refinement in how group processes may be utilised as a factor in shaping multiple and/or shared problem definitions.

Alternatively, in hospital settings where assessment procedures may form a larger part of a professional's clinical work, it may be necessary to explore the way in which the model may be useful in guiding assessment practices. Since assessment procedures and feedback of assessment results are deemed to be factors that have the power to shape a client's problem definition, in a positive or negative way, it follows that the model may be a useful tool in managing the assessment process in an empowering way.

Furthermore, different methods of enquiry may also yield more in-depth knowledge about the utility and relevance of the model to different clinicians. Specifically, one may enquire as to the degree of utility and relevance the model holds for practitioners subscribing to different schools of psychotherapy, and also whether the model is as useful to therapists working with different client populations, cultural groups, minorities, etcetera. Since the utility of the model is more dependent on the clinician's understanding of, ability and willingness to embrace, its philosophical tenets it is predicted that clinicians who are more accepting of the model would show higher levels of utility and relevance than other clinicians.

A final area related to a professional context that needs further consideration, in terms of the proposed model, is that of training. Given that training in social constructionism and

other post-modern approaches to psychotherapy has traditionally been fairly abstract and of a critical nature, it poses a dilemma for training students according to the proposed model. Certainly, one of the strengths of post-modern approaches is its focus on critique of the status quo as is also evident in the proposed model. Yet, on the other hand, the model represents an understanding of different models of psychotherapy as explanatory systems of language, images and metaphors that offer new ways of accounting for clients' problems.

Thus, the model embraces the viewpoint that all models of psychotherapy are equally valid, but that their validity is determined locally in an interactive context with a specific client and therapist. Training in the use of this model would thus require a balancing act between fostering a generally critical attitude towards scientific givens, yet providing enough training and exposure to models that are based in different epistemological foundations in order to enrich their therapeutic repertoires.

7.4 A FINAL REFLECTION: THE TRUTH ABOUT TRUTHS

Much has been said, throughout this thesis, about the dangers of absolute and universal truths and also of how subtle and insidious these may creep up on a person. In fact, the proposition of a social constructionist model of therapeutic factors, as an alternative to EBPP and other common factors models, rests on the researcher's assumptions that psychotherapy models based on universal truths are less desirable than a model that allows for locally constructed truths. The researcher's desire to propose a model that rejects universal truths, however, poses a paradox in that it contains an unavoidable appeal to the reader to buy into his truth: that is that locally constructed truths are universally superior to universal truths. Having stated this paradox, the researcher acknowledges that in his critiques about truth, he cannot avoid promoting his truth about truths. The reader is, therefore, invited to engage in their own

deconstructive analysis of the proposed model and in so doing define their locally constructed truth about truths.

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