The present report is based on my 6 months participant observation of group therapy in a neurosis treatment unit (Unit). Numerous technical and organizational problems in getting the video equipment completed and workable proved to be insuperable. Thus my only empirical source was restricted to direct observations and notes made after sessions. During the sessions I was sitting in the corner of a large meeting room, outside the therapeutic "circle". Silent presence of 2–3 so called "observers" at a group session is routine practice in the Unit.

The group basically consisted of 10 patients and two therapists. Group meetings took part twice a week. Every third meeting, called "motorial training" was held by a third, specialised therapist. After each session all three therapists together with the "observers" participated in a "discussion of the group".

As time passed I became more interested (a), in interactions between the therapists and the patients rather than between the patients themselves, and (b), in a kind of therapeutic "ideology" which provides the participants of the group with the "seen but unnoticed" basis for therapeutic practices.

My basic sociological point of view on therapy comprised two ethnomethodological points: (a) social organization of therapeutic work should be investigated through the analysis of the rules of

*University of Łódź.
practical reasoning which members follow, and (b) interpretive re-
sources as displayed in members' methods (i.e., in members' inter-
pretive practices) should be treated as the proper topic of re-
search.

An important change which took place in my conception of the-
rapy rested on the fact which actually became clear to me only
during the group, namely that decisive components of the members' 
resources derive from the therapists' general orientation (in case 
of the Unit: an analytic approach to therapy). For the therapists 
the resources consist of a set of psychoanalytic rules of reason-
ning referring to psychological problems. The patients' resources 
got transformed during the group from everyday rules of reasoning 
toward some "folk" version of the analytic rules acquired in pro-
cess of therapeutic interventions.

Had the members' methods in the Unit manifested some distinc-
tive resources my research interests would have had to be expan-
ded. The research was focused not only on the activities of the 
group but extended to everything that happened before and after 
the group, pertaining especially to the "discussions".

My admitted dependence on ethnomethodology refers to the prin-
ciples (Garfinkel, 1967; Eglin, 1980 b) but not to 
specific ethnomethodological analyses of psychotherapy, as e.g. 
Turner (1972), and Rawlings (1979) and (1982). The 
ethnomethodological researches on therapy show the social organi-
ization in situ displayed in the categorization devices and the 
turn-taking system of therapeutic talk. Unfortunately, ethnometh-
do logists look at the therapeutic work as uniform activity. Thus, 
ethnomethodologists do not appreciate the relevance of distinctive 
therapeutic resources for specific members' methods in distinctive 
approaches to therapy. Besides, ethnomethodologists often confine 
themselves to the verbal channel of communication and do not take 
into account the comprehensive communication process.

Three therapies

It is often claimed that diverse kinds of therapy fall into 
three basic varieties, i.e., the behavioral, analytic and Gestalt 
approaches. Each of these approaches provides a specific defini-
tion of neurosis and recommends a specific therapeutic treatment. Behavioral therapy defines neurosis as an unfavorable learnt reaction which can be extinguished through behavioral management. In the analytic therapy neurosis is defined in terms of defensive mechanisms, i.e., repressed, unconscious mental processes which should be overcome through "insight", i.e., through acquisition of new analytic rules of reasoning. In the Gestalt therapy neurosis is treated as the lack of capacity for "being with oneself" (bearing own emotions). The therapy is aimed at gaining the awareness of oneself and the readiness for dialogic interactions.

The report: interpretive resources as displayed in members' methods

According to ethnomethodology members permanently make "the setting accountable". Undoubtedly therapists and their patients are extremely busy with making their setting accountable. They are involved in numerous practical matters two of which are most important. The initial basic statement by the patient is: My problem is that [...], but I do not know how to deal with it". The basic statement by the therapist is: "what is the main problem of P. and how to deal with it". In the process of therapy patients give their initial statement up and come closer to that of the therapist.

According to ethnomethodology members do not as a rule differentiate between resource and topic of their everyday practical reasoning, i.e., they do not try to separate the allegedly objectified topic of their interpretive efforts from the rules of reasoning which enable the intersubjective constitution of the topic. In the case of the Unit it was evident that neither the therapist nor the patients paid attention to the "constructive" character of analytic interpretation. Both sides of the therapeutic process were involved in truly practical matters, which shaped their "zones of relevance".

The ethnomethodological point of view demands taking members' resources as the proper topic of inquiry. In line with this assumption I intend to present two lists: 1) a list of beliefs and rules of reasoning which are used in the Unit as interpretive resource, as partly unsaid general orientation, strategy, or "ideolo-
1. The resource of analytic interpretation

A. Therapeutic work with the patient implies a basic change in the patient's interpretive schemes in accordance with the therapist's project.

B. The "insight" which the patient is to reach reflects the "insight" previously gained by the therapist. Therapy is a process of orienting the patient toward the "insight", i.e., toward some new knowledge of himself which is accessible through indirect indoctrination. In fact the patient gets to interpret the "true causes" of his problems in terms of somewhat folklorised, simplified, easily accessible analytic framework.

C. The analytic approach assumes that deep therapeutic interpretation of the patient's problems meet, as a rule, his resistance. Nevertheless, Freud successfully derived basic neurotic problems from the early stages of the patient's family life. The patient is then more ready to accept, for instance, that he missed parental love in his childhood. If the patient accepts such interpretation of his life history he cannot refuse the therapeutic interpretation of his current problems, which are now treated as direct implications of his childhood experience.

D. The "insight" is the main component of the therapeutic sequence: "to experience, to name, to make". The "insight" pulls the patient through and allows him to live again and act in everyday life.

A comment on analytic resource

Analytic therapy aims at gaining some specific interpretive competence. The intended competence is predetermined by a set of notions and rules which can be easily summarised and codified. Psychoanalysis is then based on "closed discourse" which greatly
facilitates the link between psychoanalysis and the scientific "province of meaning" (cf. section 2.C) It is worth noting that analytic discourse is historically and culturally bound; psychoanalysis appeared in the European culture most of all as demystification of philistine hypocrisy on sexuality. In fact it quickly gained objectified, academic status. One reason for this was the assumed essential supremacy of the analyst over his patients which paralleled the supremacy of the physician over the patient (in medicine) and the supremacy of the man of sciences over the common man (in science).

An analytic understanding of the patient's problem consists in the use of an interpretive scheme taken from outside of his experience and implies a change in the patient's own understanding. However, analysts deny the demystifying, persuasive character of analytic therapy. One reason is that analytic therapy is well accommodated to the scientific "province of meaning" which is perfectly immune to self-critical reflection. The therapists' resistance reminds of a similar resistance by conventional methodologists in social sciences against the ethnomethodological account of questionnaire and coding procedures. Analytic therapists are ready to admit the demystifying character of their activities only on the condition that demystifying interpretation be considered a universal feature of any kind of therapy. In the analytic point of view the difference between the analytic and Gestalt approaches is quantitative and not qualitative, and lies in the fact that Gestalt notions are more recent, less distinct defined and, so far, unsystematized.

2. The members' methods in analytic therapy

A. Talk at the therapeutic group.

a. Substitution of directive interventions for indirective ones in the process of the therapeutic group.

During first group meetings the therapists are almost utterly undirective, i.e., they allow their patients to say whatever they wish. The therapists' activity is almost completely limited to short résumés delivered in the middle and at the end of each session. Patients as a rule provide so called "symptomatic", surface
versions of their problems (e.g., "My main problem is that I am afraid of exams", "The reason for my being here is my anxiety"). The reaction of the follow-patients consists in numerous detailed questions and pieces of "practical advice" which are heaped on the patient who has stated his "main problem" (e.g., in reaction to the declaration "I am horribly afraid of exams" he may be asked the question "Do you study alone" or provided with the advice "You should study together with your friends").

It is obvious that the "questions and advice" are hardly helpful, especially when the patients begin to declare still bigger personal problems and are confronted with similarly useless detailed questions and advice. The routine result is a crisis situation, which consists in: a) open as well as covert aggression toward the therapists, b) distrust in the competence of therapists, c) growing uncertainty as to what should be done at sessions, d) increase of neurotic symptoms in the patients' private life (examples of a), b) and c): long silences, "The group gives me nothing", "We had better read book or so", "I do not know what we are to do here, I could only repeat what I have already said").

As time went on the number of therapeutic interventions increased. One kind of these interventions concerned the group as a whole (e.g., "Who of you had similar experiences as Mr X", "Please, tell each person here one after another, how to they feel about you"). The second kind of interventions aimed at probing the individual problem deeper (e.g., "I think we have already completed the period of questions and advice", "Up to now we've been moving rather on the surface, haven't we?", "Who of you wants to work on his problem today?").

The therapists may now expect confessions by the patients referring to their life stories. If such stories are told, the therapists introduce analytic interpretation of earlier family experiences. Their interventions are now much more carefully listened to, for the reason of their previous absence and present scarcity. Something begins to get organized in the patients' views on their problems, aggression toward the therapists decreases, the therapists regain their authority and sometimes sympathetic respect. The so-called "true therapeutic work" begins.

Therapists account for such direction of "group development" in terms of resistance. If the true cause of neurosis is suppress-
sed into the patient's subconscious it is very hard to reach that stratum directly and it takes time. From the ethnomethodological point of view it might be argued that the efficiency of this line of "group development" derives mostly from the initial lack of accountable schemes of interpretation and the following adoption of such schemes from the therapists.

b. "K" categorization device.

Harvey Sacks (1972) defined the "K" categorization device as "a collection constructed by reference to special distribution of knowledge existing about how to deal with some trouble". "Collection »K« is composed of two classes (professionals, laymen) [...] 1. All those occupational categories for which it is correct to say that Members of the named occupations have special or exclusive rights for dealing with some trouble (a) are occasional occupants of K's class (professionals). 2. For any given trouble for which such an occupation exists as 1. above locates, that occupation (or occupations) constitutes the category exclusively occupying the (professional) class, where all who are not Members of it are undifferentiatedly occupants of the K class (laymen). Thus, for any given trouble, incumbency in one of the classes excludes incumbency in the other" (Sacks, 1972, p. 37, 39-40). Originally Sacks referred to staff members of emergency psychiatric clinic and suicidal callers. Peter Eglin listed other examples of "K" identified in the course of numerous other ethnomethodological studies (police-caller, therapist-patient, doctor-patient, teacher-student, interviewer-interviewee in social research (Eglin, 1980 a, p. 73-74)).

I have observed the following three instances of "K" in therapeutic talk:

1. A version of Socratic "maieutic" method; it was the patient who finally expressed the analytic gist but the therapist was in the long run responsible for this.

2. "Adult-child convention", by the use of which the therapist often "helps" his patients in finding terms for their feelings. Adults sometimes speak for their children, as if on their behalf, e.g., "What a big boy I am...", "How nice I look in my new dress...". The therapists often try to name feelings and thoughts of the patients in a similar manner, e.g., "I am angry...", "I made so many efforts and they weren't noticed by my mother..."
3. Direct imposition (rarely used, for fear of expected resistance), e.g., "I think it was not like you said", "I have the feeling that it was you who dominated in your marriage".

a. Reinforcement of folk-analysts.

Therapists sometimes encourage patients to make attempts at interpreting other patients' problems (e.g., "Who of you has got some idea?"). Some of the patients skillfully adopt the therapeutic rules of reasoning, e.g., "I think I still do not know you. You have said many words but you didn't tell us anything about yourself", or even engage themselves in analytic interpretation of their fellow-patients, e.g., "Wasn't your fear of poor performance the fear of your mother?". Therapists reinforce the efforts of folk-analysts by slight but noticeable confirmation. The contribution of folk-analysts facilitate therapeutic work because the resistance to therapists is omitted. They are also treated by analysts as signs of "change for the better" on the part of folk-analysts.

The activities of folk-analysts reduce the restrictiveness of "K" Membership Categorization Device. The point is that the goal of analytic therapy is to change the "bona-fide" layman into a folk-analyst, at least as far as the patient's own problems are concerned. The analytic therapy is first of all a process of transformation of the patients' interpretive schemes in the direction projected by therapists, and that is why mere binary notions, like "K" MCD, cannot suffice here.

B. Relation of speech to non-verbal communication and to comprehensive expression.

The analytic therapy is talk therapy. The main therapeutic process is assumed to take place during conversational sessions. At those meetings as well as therapists are chary of non-verbal gestures. The analytic skill acquired by some of the patients does not help them to remove the observable blockades pertaining to their paralinguistic and non-verbal means of expression. Instead, the acquired analytic skill often results in stable, highly aesthetic and calm appearances during conversational meetings and in the relatively rigid behaviour during "motorial training".

In the analytic approach verbal expressions are treated as a container for decisive inner processes. The analytic therapy (in strict sense of the term) works on the verbal means of expression having neither influence nor interest in promoting the non-verbal or comprehensive potencies of expression.
The "closed discourse" of "discussions".

The repertoire of notions used in "discussions" consists of basic analytic notions (e.g., resistance and transference) and highly traditional sociological notions regarding the social group (e.g., group structure, leader, norms, goals, values, subgroups, etc.). Hence, it might be argued that the discourse of "discussions" is "closed". It means that: (a) discourse is rigoristically based on strict conceptual framework, and (b) there is neither encouragement to nor interest in a systematic reflection on the premises of own conceptual framework. Analysts are practically interested in making particular "cases" and group events accountable and not in examining the validity of their own discourse. It might also be suggested that both the analytic and the sociological notions of therapeutic discourse are treated veristically by their users. It means that alternative attitudes toward own discourse, i.e., conventional and critical attitudes, are out of the reach of therapists (cf. some further remarks on discourse in the humanities, in my paper, 1985).

Conclusions

Some components of analytic resource have been identified and some of their methodical manifestations documented. It has also been stressed that the three main approaches to therapy (behavioral, analytic and Gestalt) base on distinct resources.

The trouble is that therapists do not look at the distinct approaches to therapy in terms of their overall validity but rather in the practical terms of their limited applicability in a given case. From the practical point of view each approach to therapy appears to be fitted for some specific kind of neurotic problems (cf. the remarks by Kovell, 1978). The practical, instrumentalist treatment of the therapeutic approaches is not theoretically indifferent because it leans toward the general behavioral position (i.e., distinctive approaches come to be considered in terms of the situated applicability of the associated techniques).

Finally, it should be underlined that the present paper is ba-
sed on a preliminary, unsystematic empirical attempt which should be followed by systematic, data driven investigation of interactional processes in psychotherapy.

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Marek Gzytewski

PSYCHOTERAPIA JAKO PROCES INTERAKCYJNY
PRÓBA EMPIRYCZNA

Autor przedstawia swe obserwacje dotyczące półrocznego okresu rozwoju grupy terapeutycznej, kładąc nacisk na charakter interakcji między terapeutą a pacjentem. Podjęta próba analizy empirycznej korzysta z perspektywy teoretycznej opracowanej przez etnometodologię, a zatem odnosi się do reguł myślenia potocznego stosowanych przez uczestników interakcji.