Marek Czyżewski[*]

PSYCHOTHERAPY AS INTERACTION PROCESS. AN EMPIRICAL ATTEMPT

The Setting

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, specialized 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-
ing 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 (G a r f i n k e l, 1967; E g l i n, 1980 b) but not to
specific ethnomethodological analyses of psychotherapy, as e.g.
T u r n e r (1972), and R a w l i n g s (1979) and (1982). The
ethnomethodological researches on therapy show the social organi-
zation in situ displayed in the categorization devices and the
turn-taking system of therapeutic talk. Unfortunately, ethnometho-
dologists 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 unfavourable learnt reac-
tion which can be extinguished through behavioral management. In
the analytic therapy neurosis is defined in terms of defensive me-
chanisms, 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 neuro-
sis is treated as the lack of capacity for "being with oneself"
(bearing own emotions). The therapy is aimed at gaining the awa-
reness 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 im-
portant. 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 of that of the therapists.

According to ethnomethodology members do not as a rule diffe-
rentiate between resource and topic of their everyday practical
reasoning, i.e., they do not try to separate the allegedly objecti-
fied topic of their interpretive efforts from the rules of reason-
ing which enable the intersubjective constitution of the topic. In
the case of the Unit it was evident that neither the therapists
nor the patients paid attention to the "constructive" character of
analytic interpretation. Both sides of the therapeutic process we-
re 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 assum-
ption I intend to present two lists: 1) a list of beliefs and ru-
les of reasoning which are used in the Unit as interpretive reso-
urce, as partly unsaid general orientation, strategy, or "ideolo-

gy", and 2) a list of members' (therapists' as well as patients')
methods which are the display (accomplishment) of the rules of re-
asoning in practical circumstances of therapeutic work in the Unit.

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 thera-
pist'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 accesible through indirect indo-
ctrination. In fact the patient gets to interpret the "true cau-
ses" of his problems in terms of somewhat folklorized, simplified,
easily accesible analytic framework.

C. The analytic approach assumes that deep therapeutic inter-
pretation of the patient's problems meet, as a rule, his resistan-
ce. Nevertheless, Freud successfully derived basic neurotic pro-
blems from the early stages of the patient's family life. The pa-
tient is then more ready to accept, for instance, that he missed
parental love in his childhood. If the patient accepts such inter-
pretation of his life history he cannot refuse the therapeutic in-
terpretation 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 se-
quence: "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 summarized 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 accomodated 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 indirictive 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 help-
ful, especially when the patients begin to declare still bigger
personal problems and are confronted with similarily useless de-
tailed questions and advice. The routine result is a crisis situa-
tion, which consists in: a) open as well as covert aggression to-
ward 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 no-
thing", "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 incre-
ased. 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 in-
dividual 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 res-
pect. 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 suppres-

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 S a c k s (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 (s) 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" (S a c k s, 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 (E g l i n, 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 lok 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".

c. 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 ascetic 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.

C. 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 K o v e l, 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 interac-
tional processes in psychotherapy.

References

C z y ż e w s k i M., 1985, Człowiek nie ma osobowości, "Acta
    Universitatis Lodziensis", Folia sociologica 12.
E g l i n P., 1980 a, Talk and Taxonomy, John Benjamins B. V.,
    Amsterdam.
E g l i n P., 1980 b, Culture as Method, "Journal of Pragmatics",
    vol. 4.
G a r f i n k e l H., 1967, Studies in Ethnomethodology, Prentice
    Hall, Englewood Cliffs.
K o v e l J., 1978, A Complete Guide to Therapy, Penguin,
    Harmondsworth.
P e r l s F., 1981, Cztery wykłady, [in:] K. J a n k o w s k i
    [ed.], Psychologia w działaniu, Czytelnik, Warszawa.
R a w l i n g s B., 1979, Two practical Concerns for Therapists,
    "Manchester Sociology Occasional Papers", no. 2.
R a w l i n g s B., 1982, Turn-Taking as an Organizational Mat-
    ter, paper for presentation to the Tenth World Congress in
    Sociology, Mexico City (Sub-Section 5: Speech in Organiza-
    tions).
S a c k s H., 1972, An Initial Investigation of the Usability of
    Conversational Data for Doing Sociology, [in:] D. S u d n o w
    [ed.], Studies in Social Interaction, The Free Press, New York.
T u r n e r R., 1972, Some Formal Properties of Therapy Talk, [in:]
    D. S u d n o w [ed.], Studies in Social Interaction, The
    Free Press, New York.
Y o n t e f G. M., 1976, Gestalt Therapy: Clinical Phenomenology,
    [in:] V. B i n d e r, B. R i m l a n d (eds.), Modern The-
    rapies, Prentice Hall, Englewood Cliffs.

Marek Czyżewski

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.