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Ontological and Epistemological Reflexivity: A Core Skill for Therapists

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This paper develops the argument that a core skill needed to be an effective therapist is to have acquired an awareness of one's own ontological and epistemological position in relation to one's work as a therapist. In the same way that researchers need to develop reflexive awareness of their assumptions about what there is to know (ontology) and how they can come to know about it (epistemology), therapists need to be aware of their fundamental assumptions about human beings and the world they live in (ontology) as well as their beliefs about how best to develop an understanding of their clients and the meaning(s) of their experiences (epistemology).

Regardless of which particular therapeutic model is adopted, the language used to talk about (and in) therapy, the kinds of questions asked of clients and the comments/interpretations offered, all presuppose and reinforce particular versions of human being and experiencing which are themselves not usually questioned or challenged during the course of therapy. In this paper it will be argued that it is essential that therapists are aware of their own fundamental assumptions about what it means to be human, and that they recognise their ontological and epistemological positions as positions that they are taking (rather than perceiving them to be self-evident truths). This is important for two reasons: i) if clients do not share the therapist's assumptions (ie. their 'model of the person'), the therapeutic work cannot proceed and be effective; ii) without such an

awareness, therapists are at risk of unwittingly imposing their own model of the person upon the client which raises ethical issues.

Key words: ontological and epistemological assumptions; model of the person; therapist reflexivity; 'vocabulary for action'

Self-knowledge is generally understood as an important requirement for those wishing to practise counselling and/or psychotherapy (McLeod, 1998). Many training programmes expect trainees to engage in personal therapy to develop a deeper understanding of themselves, and the role of their personal history in shaping them. Self-knowledge is seen as important because therapists need to recognise their own responses to clients' material and to ensure they remain open to their clients' experience in all its otherness rather than subsuming it into their own life-world or projecting their own thoughts and feelings onto their clients. Self-knowledge also helps therapists engage in appropriate and timely self-care, and reduces their risk of practising unethically.

In this paper I argue that ontological and epistemological reflexivity constitute neglected dimensions of self-knowledge and that such reflexivity ought to be considered a core skill for therapists. Just as researchers need to develop reflexive awareness of their assumptions about what there is to know (ontology) and how they can come to know about it (epistemology) (Willig, 2012a), therapists need to be aware of their fundamental assumptions about what it means to be human (ontology) as well as their beliefs about how best to develop an understanding of their clients (epistemology). Otherwise the therapist will not be mindful of any differences between their own and their client's fundamental assumptions about what it means to be human and the implications of this for their views on how best to develop an understanding of the client's distress. This could have negative consequences for the quality of the relationship between client and therapist and may compromise their working alliance and thus have a negative impact on the therapeutic work (Ardito & Rabellino, 2011). Any agreement on the goals of the therapeutic work as a whole, the tasks that need to be completed in each session to move closer to that goal, and the

establishment of an emotional bond between client and therapist (the three components of the working alliance) presupposes that client and therapist share assumptions about the nature of human being and experiencing. If they do not, this will need to be negotiated as the therapeutic work proceeds (assuming the client returns after the initial session). If therapists are not reflexively aware of their own ontological and epistemological assumptions, they risk missing this opportunity for joint reflection and may alienate the client in the process.

Despite some very insightful reflection on this and related issues (Christopher, 1996; McLeod, 1998; Rennie, 1998; Harland et al. 2009; Read et al. 2017; Van Deurzen, 1988), epistemological and ontological reflexivity do not feature prominently in counsellor and psychotherapy training syllabi. This paper seeks to address this issue by making the case for a more explicit engagement with epistemology and ontology within the context of counselling and psychotherapy training and practice.

Ontology and Epistemology

The terms ontology and epistemology are variously defined in dictionaries and textbooks. However, the definitions provided share key features which characterise these constructs, as follows:

Ontology

Ontology is concerned with what exists. It can be described as a theory of being in that it attempts to elucidate what it means for something to exist, to 'be there'. Ontology also asks questions about what kinds of things exist and make up the world. A person's ontology identifies the things they assume exist. Every theory is based on an ontology because every

theory presupposes that certain entities or processes exist. Ontology refers to the taken-for-granted upon which we build our understanding of the world.

Epistemology

Epistemology is concerned with the nature of knowledge- its possibility, its scope, its limits and the processes by which it can (or cannot) be acquired. It addresses questions about what characterises actual knowledge (as opposed to beliefs or ideas about something), about what can be known, how we acquire knowledge and how certain we can be about its validity or truth value. All claims to knowledge are based on epistemological assumptions regarding the nature of knowledge and how true knowledge can be produced; in other words, all claims to knowledge are supported by a theory of knowledge.

Ontological and Epistemological Reflexivity in Counselling and Psychotherapy

All models of counselling/psychotherapy contain ontological and epistemological assumptions. McLeod (1998) notes that whilst on the surface approaches to counselling/psychotherapy may appear to simply represent different sets of strategies for helping people, “[U]nderneath that set of practical procedures (...) each approach represents a way of seeing people, an image of what it is to be a person” (p.27). To illustrate this, we shall take a closer look at the three models of practice included in all training programmes in the UK ¹:

¹ The purpose of this presentation of models is to demonstrate that all models are underpinned by assumptions; I am aware that some readers may take issue with my rather simplistic characterisation of some of the models.

The Psychoanalytic Model. The psychoanalytic model works with the notion of a split self and presupposes the existence of a psyche containing both conscious and unconscious realms, thus constructing the person as driven by often unconscious desires, as anxious and defended, conflicted and dynamic (ontology). It assumes that knowledge about a client's psychodynamics can be obtained by accessing unconscious content through interpreting the client's material and bring to light its deeper meanings and motivations (epistemology). As a result, the client acquires a better understanding of themselves and their motivations, and this can help them find more effective ways of having their needs met and develop more satisfying relationships.

The Person-centred Model. The person-centred model constructs the person as striving to fulfil two primary needs: i) the need for self-actualisation, and ii) the need to be loved and valued; and assumes that every person has the potential to express their true self given the right condition (ontology). It proposes that knowledge and understanding of the true self can be obtained by creating core conditions (including acceptance, congruence and empathy) which facilitate the expression of the client's true self (epistemology) which will reduce the client's psychological distress.

The CBT Model. Using information-processing metaphors, cognitive models construct a version of the person as comparable to a computer; akin to a piece of hardware that has the potential to be programmed in different ways with different experiential and behavioural consequences (ontology). The systematic identification of dysfunctional, maladaptive and often automatic thoughts (such as overgeneralisations, dichotomous thinking, or personalisation) allows the therapist to access the 'faulty' programme (epistemology).

Reprogramming the client takes place through techniques such as psychoeducation, thought experiments, and reframing, the result of which is to change the way the person conceptualises their experiences and consequently how they feel and behave.

Ontological and epistemological assumptions do not only characterise mainstream approaches to counselling and psychotherapy. Recent approaches informed by social constructionism which challenge the notion of the individual as the source and locus of distress have their own foundations. For example, systemic family therapy is based on the premise that an individual's distress is a manifestation of something happening between members of the family group (ontology) and that it can best be understood by focusing on the system ('the family') that has produced it (epistemology). Social constructionist narrative therapy takes as its starting point the idea that people's understanding of themselves (that is, the stories they tell about themselves) are shaped by the dominant narratives available in the surrounding culture (ontology) and that to bring this process to light, client and therapist need to externalise the client's problem (recognise its storied origin) and deconstruct the dominant narrative that underpins it (epistemology).

Taking a closer look at a psychotherapeutic model's ontology and epistemology highlights the generativity of theory and shows how each model constructs its own version of human nature and therapeutic change. McNamee (2004) draws attention to the way in which adopting a theoretical perspective provides us with a 'vocabulary for action' which invites certain ways of thinking and acting. Different models of therapy enable different ways of relating to oneself and others, and allow different experiential life worlds to emerge. By foregrounding a model's ontology and epistemology we draw attention to its productive capacity and its role in creating experiential and social realities.

Reflexive awareness of the generativity of one's working model(s) ought to be considered a core skill for therapists because our preferred construction of what it means to be a person (ontology) shapes the type of self-understanding we seek and which interpretations of our experience are be open to (epistemology). Regardless of which particular therapeutic model is adopted, the language used to talk about (and in) therapy, the kinds of questions asked of clients and the comments/interpretations offered, all presuppose and reinforce particular versions of human being and experiencing.

I want to reflect on the ways in which such ontologies and the epistemological assumptions that support them inform psychotherapeutic practice and argue that it is essential that therapists are aware of their own fundamental assumptions about what it means to be human, and recognise their ontological and epistemological positions *as* positions (rather than perceiving them to be self-evident truths). This is important for two reasons: i) if clients do not share the therapist's assumptions (their 'model of the person'), the therapeutic work cannot proceed and be effective due to an underlying philosophical incompatibility between client and therapist's worldviews (see McLeod, 1998, p. 28; Van Deurzen, 1988, p.1) ; ii) without such an awareness, therapists may unwittingly impose their own model of the person upon the client. This raises ethical issues because the client may be socialised into the therapist's model without this being acknowledged. It may, of course, be helpful for the client to embrace a different view of their humanity as this may allow them to approach themselves with more acceptance and compassion, and thus decrease their distress (in a sense, this is what therapy is all about, and a client who seeks out a therapist is asking to be affected by the therapist's presence and input). However, given the power imbalance between client and therapist, there is a real danger of the therapist's model of the person being imposed upon the client. Therefore, the therapist's reflexive

awareness of their ontological and epistemological assumptions is an essential part of ethical practice (McLeod, 1998; Friedman, 1982; and Willig, 2012b).

Ontological and Epistemological Reflexivity in Action

I suspect that as therapists we choose our preferred model of practice based on the extent to which it corresponds to our pre-existing understanding of what it means to be a person; that is, our ontological commitments. Our chosen model speaks to us because it fits with our existing beliefs about human nature and/or because it offers a construction which resonates with the questions and thoughts we may be grappling with in relation to the human condition.

Reflections on my own position

I remember becoming acutely aware of the strength of my own deeply held beliefs about these matters when working with a client who constructed herself as a split subject in our sessions. The client stressed her lack of conscious awareness of what she felt or desired (“I don’t know what I want”; “I don’t know what I feel”). At the same time, she reported experiencing strong feelings of anger and sadness which she described as “unjustified” or “unreasonable” and presented as not belonging to her conscious self (“that’s not me”). When I invited her to explore the meanings of her experience, she often reminded me that I was the therapist and expressed a desire for me to reveal her true self to her.

In our sessions, our different conceptualisations of what it meant to be (or have) a self, emerged. My client constructed herself as an enigma, a puzzle or problem to be solved by me, her therapist. I rejected the role of the expert, inviting my client to explore her

thoughts and feelings and give meaning to her experiences. I encouraged my client to reflect on her construction of a split self, how this positions her, what she gains from it, how it may limit her experience and what it means for our relationship. When confronted with the differences between my client's and my perspective on her situation, it became apparent that my own model of the person (strongly influenced by my reading of existential philosophy and its application to psychotherapeutic practice²) was informing my interventions and my expectations of my client. I realised that my commitment to the idea that meaning must be made by the individual in and through his/her own struggle with the human condition (having been, as Heidegger described it, "thrown into the world") meant that I saw it as the client's responsibility to make sense of herself and her experiences (albeit with the help of being in conversation with an empathic and concerned other). In our work together, I assumed my client had a choice about how to relate to herself and to others, and I interacted with her in a way that positioned her as the author of her life story.

Explicit positioning

A therapist's ontological and epistemological assumptions inform their practice both explicitly and implicitly. Explicitly, they can be declared via a therapist's chosen label (for example, by referring to themselves as a 'person-centred therapist' or 'cognitive-

² An existential approach to psychotherapy/counselling starts from the premise that human beings are "condemned to be free" (Sartre, 2003, p. 462), and that the human condition is characterised by the agonised awareness of its own freedom and responsibility to make life meaningful for itself (ontology). Giving meaning to one's existence requires interpretation and that means making choices and taking responsibility for those choices; a never-ending process which each person has to engage in (epistemology).

behavioural practitioner') and/or they can be outlined in a descriptive statement of their chosen model of practice (for example on their webpage or during the first session with a client). Explicit declarations also feature when interpretations or explanations of the client's experience and behaviour are informed by the theoretical premises of the therapist's model of practice. Here are two examples of therapists' introducing themselves and their approach (taken from the website of a provider of counselling and psychotherapy in the UK):

Example 1:

I like to consider people from the perspective of words and language. The stories that we tell ourselves and the ways we narrate our own lives can be incredibly liberating...or painfully constraining. We can all too easily find ourselves at the wrong end of punishing self-talk, and the words we use—whether spoken or thought—can have an extraordinary power over us. Left unchecked, the weight of all those self-imposed expectations can lead to a debilitating sense of distress.

However, these words and stories are also malleable: It is possible to change our story, adapt the rules, and be liberated by learning to change the way we judge and perceive ourselves.

Example 2:

While I primarily work using Cognitive Behavioural Therapy (CBT), the first step is to create a safe, honest, and trusting relationship that can allow you to share the feelings that have become difficult and painful. Once achieved, we will look at the specific cognitive and behavioural patterns that are causing problems and may need change.

Some clients may need to reach a deeper understanding of the historical social context in which they developed difficulties. I also work using Cognitive Analytic Therapy (CAT), which involves an initial exploration of experiences with key people in your life. This helps us understand how you have learnt to relate to others and yourself in particular ways, and identify how these relationship patterns may now be holding you back. We then experiment with new ways of relating to yourself and others in your current situation.

Both introductions contain explicit accounts of the respective therapist's ontological and epistemological commitments, and both contain information about their preferred model of the person (Example 1 constructs the person as narrator with the potential to learn to tell a different story; Example 2 constructs the person as subject to learned patterns of behaviour and thinking which have their origin in social contexts of the past and which can be replaced with new patterns). Both also construct the process of change as a process of learning which, by implication, requires an instructor (that is, the therapist) to facilitate this.

Explicit declarations of ontological and epistemological commitments also occur during therapy sessions. Therapists who adopt a more didactic approach to psychotherapy/counselling, for example through the use of psychoeducation or theory-driven interpretations, are likely to use more explicit formulations of their positions than therapists who adopt a less openly directive approach. Some models of practice, such as cognitive-behavioural therapy or compassion-focused therapy, require the therapist to introduce the client to the model and its premises and methods at the beginning of the work, and this means that an explicit statement of its ontology and epistemology will have

to be made. However, an explicit declaration of a chosen model's ontology and epistemology does not mean that its status as a model of the person based on a set of assumptions is necessarily acknowledged. Rather, the particular assumptions about what it means to be human and about how best to develop an understanding of the client's experience are often naturalised and taken to represent the truth about human psychology; consequently, the client is encouraged to experience themselves as enlightened about the nature of psychological functioning (rather than socialised into a particular vocabulary for action).

Implicit positioning

A therapist's ontological and epistemological assumptions also inform their practice implicitly. Just as researchers need to develop a reflexive awareness of how their ontological and epistemological assumptions inform the research questions they are asking and the methodological choices they make (Willig, 2012a), therapists need to be aware that the questions they ask and the comments they make in a therapy session presuppose and reinforce particular versions of human being and experiencing. They also normalise some ways of being and experiencing, and problematise others. Even apparently innocuous questions designed to simply signal the therapist's curiosity and open-mindedness always contain normative assumptions about human experience and they always imply a model of the person. For example, "And how did you feel about that?" suggests that an emotional response is expected in the circumstances (after all, the question does not ask "Did you feel something?" but "How did you feel?"); it presupposes that it is a response to something in particular ("How did you feel *about that*?"), and that such a response is of significance or at

least of interest (why else ask about it?) The question, therefore, constructs the client as someone who ought to have had an emotional response, knows what that response was, is able to provide a suitable label, and recognise its significance. By being asked the question and being expected to provide a response to it, the client is gently being socialised into a particular 'vocabulary for action' (see McNamee, 2004) and a way of relating to themselves (in this case, a way of relating that involves expecting oneself to experience emotional responses to particular situations or events).

Ontological and epistemological limits to collaboration

It is worth examining what it means when therapists talk about working 'collaboratively' with their clients, as this implies a degree of flexibility or fluidity of the therapist's assumptions. A commitment to collaborative working does nothing to loosen the therapist's ties with their assumptions. References to collaboration can be found across models of therapy (Dattilio & Hanna, 2012; Wiseman, Tishy & Barber, 2012; Paré, 2013). Collaboration has been described as an important attribute of contemporary psychotherapy, characterised by a "respectful, mutual, cooperative relationship" (Kazantis & Kellis, 2012, p.133). A collaborative working style has come to be seen as a desirable attribute compatible with diverse approaches to psychotherapeutic work. For example, within the context of cognitive-behavioural therapy the establishment of common goals in treatment and the client's active involvement in the case formulation of their problems and the development of a treatment plan, are presented as evidence of collaboration. Dattilio and Hanna (2012) describe CBT's practice of 'collaborative empiricism' (p.146) thus:

Collaborative empiricism entails a cooperative effort between therapist and patient in devising a treatment plan and incorporates cohesiveness between the patient and the therapist as they explore together through discovery and experimentation those aspects of the patient that contribute to dysfunction. A number of specific techniques employed within this process allow the therapist to help patients to process their cognitions, such as identifying automatic thoughts and underlying schemas, address regulation of their emotion, and monitor their behavior. This goal is accomplished by jointly generating activities and homework assignments to keep the engagement fluid between therapy sessions.

Evidently collaborative empiricism requires client and therapist to collaborate in the application of CBT principles to the client's material, rather than in devising the model of practice they will be working with. There is no negotiation around whether or not to theorise the client's distress in terms of the effects of automatic thoughts and underlying schemas for example, or whether to accept the idea that emotions are the products of cognitive processes. This suggests that a commitment to collaborative empiricism still presupposes that the client shares the therapist's assumptions as these underpin their collaborative practice. Dattilio and Hanna's (2012) account of a case study of collaborative working in CBT confirms that a commitment to collaborative empiricism does nothing to dislodge the therapist's loyalty to their pre-existing model of the person. Their account of collaboration frames this activity in terms of the client being educated about their own psychological processes:

Even during the initial assessment phase, the collaborative aspect of educating Jason to the need for evaluating his symptoms using empirical measures facilitates a basic understanding of the severity of his symptoms. The results of such an assessment

will serve as “grist for the therapeutic mill” in setting future agendas in ameliorating his symptoms (ibid., p.149)

And a little later:

One of the goals in therapy, aside from reducing his panic attacks, involved teaching Jason how his learned rigid responses to emotions were limiting his ability to not only feel grief and rage but also think deeply about what such loss meant to him and what beliefs it evoked (...).” (ibid., p.150).

This is not unique to CBT. Although other models may not use the language of education and their approach to socialising the client into their chosen model’s ‘vocabulary for action’ may be more subtle, collaboration in therapy usually requires the client to subscribe to the therapist’s model of practice. For example, Wiseman, Tishby and Barber’s (2012) account of collaboration in psychodynamic therapy starts by emphasising that contemporary relational psychotherapy recognises that the therapist does not own the truth about the client, and that client and therapist bring their subjectivities to the process of co-constructing meaning together. Citing Safran (2003), they define collaboration as follows (Wiseman, Tishby & Barber 2012: 138):

Collaboration in relational therapy involves the process of co-creation that occurs both consciously and unconsciously, which through negotiation leads to new meanings. In the ongoing process of negotiation, both patient and therapist “struggle to sort out how much they can accommodate to the other’s views about

treatment tasks and goals, without compromising themselves in some important way (Safran, 2003, p. 439)".

This sounds as though client and therapist feed into the process of meaning-making equally and without the expectation that some meanings are privileged over others. However, even here we can identify ontological and epistemological assumptions which inform this account of collaboration. There is the assumption that the process of meaning-making involves 'conscious' as well as 'unconscious' processes, thus drawing on psychoanalytic theory. The psychoanalytic theoretical commitments which underpin the approach emerge more clearly later. Wiseman et al. (2012) describe the process by which 'enactments' can act as the vehicle for therapeutic change:

Finally, relational therapy emphasizes the experiencing and working through of *enactments*, which are created within the transference-countertransference matrix. Working through an enactment is a collaborative process (Summers & Barber, 2010). It is at these moments that the patient's dynamics come to life (transference), as they touch on or trigger emotions and cognitions within the therapist, which, in turn, evoke his or her own characteristic interpersonal pattern (countertransference). Successful collaboration around enactments entails openness to emotional experiencing and self-reflection by both patient and therapist (p.139).

So, despite the declared commitment to the negotiation and co-creation of meanings within a collaborative relationship, the basis upon which such meanings are made remains firmly psychoanalytic and is based upon assumptions about psychodynamic

processes involving transference-countertransference as well as the role of conscious and unconscious material. Clearly, for 'successful collaboration' to work, both client and therapist need to be open to thinking in these terms and to accept their usefulness, as even 'ruptures' and disagreements between client and therapist are ultimately made sense of on the basis of these notions. Wiseman et al. (2012) write:

A collaborative examination of the dynamics of the interaction between the patient and therapist that was played out in the rupture offers participants an opportunity to learn in the here-and-now about their respective contributions" (p.138).

So, as we saw in relation to 'collaborative empiricism' in CBT, whilst the manner in which client and therapist work together may be collaborative, the choice of tools to do the work (along with the ontological and epistemological assumptions that inform this choice) is not the product of collaboration.

Clients' model of the person

It is not just the therapist who brings with them views about what it means to be a person. The client's model of themselves as a person will inform how they present themselves in their initial meeting(s) with the therapist. Some clients present themselves as a problem to be solved by the therapist. Their conceptualisation of the self is informed by the idea of a split self with parts of the self inaccessible to conscious awareness. These clients start the therapeutic conversation with the assumption that they are a mystery to themselves and do not have access to their motivations, feelings and desires. They may consult a therapist to obtain answers to questions such as "Why do I act in the way that I do?" or "What is it that

I really need ?". Within this scenario, the therapist is often positioned as 'expert' whilst the client offers themselves up for inspection and analysis; within this context the therapist's levels of expertise and skill can become a matter of concern for the client who may question the therapist's competence when answers to their questions are not forthcoming.

Other clients approach therapy sessions as a sounding board and an opportunity to hear themselves think, talk and feel in the presence of a trustworthy and empathic other. These clients are not usually overly concerned with the therapist's technical expertise and do not expect answers about what 'makes them tick' or what has 'gone wrong' with them. These clients' approach to therapy is based on a conceptualisation of the self as autonomous and unitary, inhabiting an inner space accessible to them only. Here, the therapist is expected to provide time and space for the client to explore this inner space and perhaps help them to feel more comfortable within it.

There are also clients who present themselves as a faulty piece of machinery which can be fixed to ensure smooth functioning in the future. Such clients are willing to co-operate with the therapist but presume that the therapist is equipped with the tools required to do the job. The self is conceived as the owner of the faulty piece of machinery who is taking responsibility for seeking out expert help to have it repaired. The therapist is expected to deliver an appropriate treatment which will solve the problem and restore the client's ability to function.

A client's approach to therapy and the therapist may be informed by a combination of elements from various constructions of meaning available within their sociocultural context. A client's self-presentation and expectation of the therapist is not necessarily as

clear-cut and consistent as suggested by the examples given here. However, all clients hold ontological and epistemological assumptions which inform their approach to therapy.

As is the case in relation to therapists' introductions to their way of working, clients' assumptions can be gleaned from the way they formulate the reason why they are seeking therapeutic input. Take the following email message from a client looking for a suitable therapist³:

I am looking for a counselling professional who can help me overcome my irrational fear of travelling on public transport. I would like to make contact with a professional who has experience with this particular condition.

Here, the client is drawing on medical discourse in constructing their experience of anxiety as a 'condition'; the desired therapist is cast as an experienced professional implying that they have encountered the symptom ('irrational fear of travelling on public transport') before and have successfully administered the necessary treatment. The aim of the treatment is defined as overcoming an irrational fear, to restore the client's ability to use public transport. At the same time, the client is positioning him/herself as an active agent who is seeking assistance to solve a problem for which s/he is taking responsibility. Thus, in this brief email the client sets out their implicit 'model of the person' and maps out positions for him/herself and the therapist within this context. Consider this alternative formulation of the request for therapeutic input:

³ The two emails used as examples here are composites of similar emails I have received and do not constitute reproductions of any particular client's emails.

I have been experiencing intense feelings of anxiety when travelling on public transport for some time now and feel that I need to talk to someone about this. I want to understand what this is about

Here, the client constructs their experience of anxiety as something potentially meaningful, and assumes that talking about it within the context of counselling sessions will allow him/her to reach an understanding of the meaning of the experience. S/he constructs the desire to understand her experience as a need. The desired therapist is referred to as 'someone to talk to' thus foregrounding their humanity and personhood rather than their professional status. Again, we can see that the client's formulation of their request for therapeutic input mobilises a particular way of constructing the person who will be engaged in therapy and positions both client and therapist in relation to this.

Implications for Practice

The 'authoring' of our own and others' selves through dialogue is an ethically charged act (Sullivan, 2007, p.110). It is important, therefore, to acknowledge that through our work as therapists we co-construct what it means to be a person rather than simply discover or uncover pre-existing 'selves'. Our activities contribute to the shaping of the modern self and this carries an ethical responsibility (Gergen, 1973; Furedi, 2004). It is all too easy to subtly encourage a client to construct a particular kind of self, through our questions and responses, and then to feel as though we have discovered something that has been there all along. The therapist's model of the person can be imposed upon the client who is presented with 'evidence' of this self as it is produced in the course of the session. For example, the choice of active versus passive voice in the formulation of a question can make room for

different kinds of selves to step in. Consider the difference, for instance, between asking “So what made you do that ?” and “Why did you do that ?”.

To encourage reflexive awareness of our own ontological and epistemological assumptions, and the ways in which they encourage the production of particular kinds of selves in conversations with clients, we need to engage in careful scrutiny of our own taken-for-granted notions and ways of making sense of what people do and say. One way of accessing and reflecting on one’s assumptions is to conduct reflexive interviews during which the participants take turns in asking one another to reflect on questions such as these:

1. How do you know that you know something about a person?
2. Is it possible to find out why someone did something? If so, how?
3. What motivates people to act the way they do?
4. To what extent can people know themselves? And what does it mean to know oneself?
5. What are your beliefs about human nature, and what is the evidence in support of these?
6. What is the role of language in arriving at an understanding of oneself and others?

Listening to recordings of one’s responses to these questions can be very revealing. The realisation that we hold quite specific and strong beliefs about human being and experiencing can come as a surprise, especially to those of us who like to think of ourselves as person-centred and collaborative

Another way of facilitating ontological and epistemological reflexivity involves the use of discourse analytic methods to raise awareness of the ways in which language constructs different versions of social reality and experience. The identification of discursive constructions, discursive strategies and available subject positions that characterise relevant textual material (for instance, transcripts of therapy sessions; descriptions of therapeutic models; manualised therapy materials) helps shed light on the ways in which particular versions of mental health/distress are talked and written into being (Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995; Cromby, Harper & Reavey, 2013). This approach has been advocated as a tool to develop reflexivity in both training and supervision contexts (McKenzie & Monk, 1997; Heenan, 1997) and used in research examining the process by which (preferred) meanings are constructed during therapy sessions (Kogan, 1008; Kogan & Gale, 1997; Frosh et al., 1996; Stancombe & White, 2005).

Conclusion

In this paper I have argued that ontological and epistemological reflexivity constitute neglected dimensions of self-knowledge within the field of counselling and psychotherapy, and proposed that such reflexivity ought to be considered a core skill for therapists. My recommendations are based on the premise that making assumptions about what it means to be a person is inevitable and forms the basis of our relating to other people including our clients. Even post-modern perspectives which challenge the notion of the unitary, rational subject (Henriques et al., 1998), conceptualising human subjectivity as polyvocal and characterised by a multiplicity of possible 'selves' which can emerge in different contexts (Gergen, 1999) are based upon assumptions (in this case, assumptions about the

fundamentally social nature of human being and experience, the role of language in constituting human 'selves' and the assumption that studying discourse provides us with insights into the construction of personhood). Holding views about the nature and meaning of human being and experiencing is not the problem; we are not concerned here with reflexivity as a means of removing bias. Rather, ontological and epistemological reflexivity helps us to recognise the content of the assumptions which underpin our way of relating to another person and remind us that our own assumptions about human being and experiencing are just that- assumptions.

Concluding reflections on my own practice

In the spirit of this paper's concern with reflexivity and transparency, I want to end with some reflections on where my own epistemological and ontological positions take me in relation to my work with clients. Sullivan's (2010) proposal that we incorporate the self-self relationship into our studies of experience resonates with my own model of the person. Writing about qualitative research in psychology, Sullivan (2010) draws attention to the fact that rather than presenting us with straightforward accounts of experience, research participants themselves bring an attitude of hermeneutic suspicion to their own experience:

They are not just subjects to be known but also selves as knowers- introspectionists who alter the content of their own experience by its observation- and who are capable of interpreting and re-interpreting what they had trusted as being suspicious and vice versa." (p.14)

I have been struck by the extent to which my clients question their motives, express uncertainty about the true nature of their feelings and offer possible interpretations of their actions; which often includes their reactions to other people's interpretations. As a therapist I have witnessed this struggle for meaning through which selves are made and I am aware of having contributed to it by offering meanings and self-positions through my questions and comments.

However, it has become clear that even though the desire to arrive at definitive answers about who we are and what we need can be very strong, ultimately any final meaning tends to be resisted because to accept a final meaning would mean to silence the "I", the part of the self that is the "seat of perception and ground for action" (Holquist, 1990: xxxix, cited in Sullivan, 2007: 112), and that is engaged in the process of questioning and reflecting.

Indeed, Lysaker and Lysaker (2002) suggest that psychotic states are characterised by disruptions in the dialogical self and that the loss of the ability to maintain an ongoing dialogue within the self, undermines our basic sense of self. Paradoxically, then, it may not be a fixed set of physical and psychological qualities, features and characteristics that provides us with a stable sense of self, but the ability to hold an inner dialogue about who we might be, and to maintain an active self-self relationship, that gives us a sense of coherence and unity.

These reflections have led me to conclude that perhaps what really matters is process, not content; any interpretations that I, as a therapist, may offer, function only as reference points, as possible self-positions with which my clients may engage as they reflect on what it means to be human. Perhaps the most important thing I can do for my clients is

facilitate communication between self-positions, to nurture my clients' dialogical self, by providing resources for internal dialogue through external dialogue. My ontological and epistemological reflexivity is an important part of this process as it facilitates the recognition of my assumptions *as* assumptions and for this to be made explicit during the sessions. This enables the client to develop their own relationship with these assumptions during the course of our therapeutic work together.

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