Text and Context in Counselling Psychology

Some uses of deconstruction

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Tables and illustrations

With sincere and heartfelt thanks for all their support and understanding, to Dr Don Rawson, Ruth Bagnall, Jane Wythe and my mother, Josie Davy.

In loving memory of my father Terence John Davy

Abstract

This thesis examines how deconstruction can be used to develop counselling psychology by linking postmodern perspectives framing human experience as text constructed though language and discourse, with an emphasis on the social and material contexts for the clinical practice of therapy and supervision. Deconstruction is used to develop critical realist perspectives within a social constructionist psychology, rather than to promote radical relativist models of practice.

The Literature Review examines how recent constructionist research challenges the traditional prevalence of the grief work hypothesis in psychotherapeutic work with bereaved people. The review focuses on the 'Dual Process Model of Coping with Loss' developed empirically by Margaret Stroebe, and on Tony Walter's postmodern sociological model of bereavement as a process of (auto)biographical reconstruction. The review includes an appendix presenting three case vignettes illustrating the clinical utility of these ideas. This literature review involves the deconstruction of a long-established theory of psychopathology, and also shows some uses of deconstructive tactics within bereavement therapy.

The Case Study demonstrates how deconstruction can be used as a practical form of psychotherapy in its own right, outlining the conduct of a postmodern narrative therapy with a primary care patient. In a reflexive turn, the case study is interleaved with a second commentary providing a critique of the original case study from a deconstructive feminist perspective. This emphasises the constructed nature of accounts of clinical practice, and highlights the potential for reflective writing as an aid to continuing professional development.

The Research component of the thesis presents a qualitative research interview study of clinical supervision in palliative care, based on interpretative discourse analysis of 16 individual interviews conducted with specialist palliative care professionals. The research produces two new metaphors for interpreting clinical supervision, as governance and as ritual, which have practical implications for training and professional practice.

TEXT AND CONTEXT IN COUNSELLING PSYCHOLOGY

Some uses of deconstruction

Section 1 An introduction to the doctoral portfolio

My doctoral portfolio explores some different uses of deconstruction to show how a postmodern emphasis on the textuality and narrativity of human experience can be combined with a social constructionist emphasis on the significance of context and cultural resources to inform responsible therapeutic practice.

As a counselling psychologist I am particularly interested in systemic and narrative approaches to psychotherapy. My doctoral portfolio is an attempt to revise second order cybernetic perspectives which focused on the emancipatory and transformative possibilities of language at the individual and family level, towards a third order cybernetic stance (Dallos and Urry 1999) which recognises that personal experiences are intimately embedded within wider social contexts of power, materiality and inequality, with reciprocal and potentially oppressive relationships between these. This has many similarities with Bhaskar's critical realist philosophy (1978, 1989), another theoretical resource for this work.

I will begin by discussing the place of narrative in psychology, and outline an understanding of deconstruction in relation to this. The introduction concludes with an overview of the different uses of deconstruction within the components of this portfolio, which are as follows:

Section 1 This introduction to the portfolio

Section 2 A literature review on constructionist challenges to the grief work hypothesis in bereavement

Section 3 A case study presenting a reflexive critique of therapy using a deconstructive narrative approach

Section 4 A research study developing a discursive interpretation of clinical supervision in palliative care

Dominant metaphors in counselling psychology

Psychology is not a unitary or static discipline, and the forms it takes are intimately connected with other contemporary cultural resources and practices. These provide metaphors which help organise and focus theoretical thought within psychology (Brown 1977, Chapter 4, Allman 1982), whilst also obscuring themes outside the reality constructed through the metaphor (Lakoff and Johnson 1980, Gergen and Gergen 1986, MacNamee 1992, Rosenblatt 1994). Early psychoanalytic theories drew on metaphors from hydraulic/Newtonian mechanics and Darwinian evolution, for example, in conceptualising libido and drives, and the construction of the ego from the more primitive and bestial forces of the id (Schafer 1980, pp. 30-31). Humanistic psychologies borrowed from religious and spiritual practices (Halmos 1965, McLeod 1997, p. 7) and Western notions of liberal democracy, individual enfranchisement and self-advancement. Cognitive theories and early systemic thinking rested on computational metaphoricity and related fields such as cybernetics and information processing. More broadly, Stiles and Shapiro (1989) have shown how most psychotherapeutic studies are constructed around a 'drug metaphor'.

The relations between psychology and other cultural forms are complex and reciprocal. Rose's explorations of the 'psy-complex' (1985, 1989) demonstrate how psychological frameworks for interpreting and influencing experience have infiltrated other domains, such as the legal system, popular media, and educational practices. This interpenetration can also be traced more specifically in relation to psychotherapy (e.g. Pennebaker 1993, Parker 1997).

The rise of the narrative metaphor

From the 1970s onwards there has been a growing interest in the use of a narrative metaphor within psychological and social studies including therapy. Theorists including Shotter (1975), Schafer (1980), Spence (1982), Sarbin (1986), Polkinghorne (1988) and Mair (1989) have argued that positivist propositional knowledge provides an inadequate basis for understanding and intervening in human relationships involving people trying to make sense of experience situated within richly structured socio-historical contexts. They claim instead that personal and

cultural experiences are constructed through the creation and performance of narratives and stories. Within the psychoanalytic schools, Lacan argued vigorously that 'language is the condition for the unconscious', reversing the Freudian position (Parker 1997, pp. 191-98, Lacan 1977, 1979). Concurrently, sociologists of scientific knowledge have described how 'science' operates as a rhetorical process, strategically justifying the production and privilege of certain 'facts' over others, rather than a consistent positivist methodological process (Gilbert and Mulkay 1984). The scientific process can be seen as a certain kind of narrative genre enjoying particular privilege in late modernity.

Narrative and constructivist therapies

A focus on the place of narrative in the construction of identity and experience has been influential on the recent development of cognitive and personal construct therapies[1], and second order cybernetic systemic therapies emphasising the familial construction of meaning (Dallos 1991). Constructivists focus on processes by which individuals, or small social units such as couples or families, make sense from their sensory percepts as they interact with an environment (akin to Piaget's (1955) image of the child as a lone explorer making sense of their world). Constructivist therapists use narrative metaphoricity to help individuals review and revise their life stories and the ways in which they develop these (e.g. Viney 1993). Recent schema-focused developments within cognitive therapy (Young 1994), cognitive-analytic therapy (Ryle 1991, 1995) and attempts to integrate concepts of attachment experiences and related life-scripts with family therapy (Byng-Hall 1995) are examples of such approaches concerned with individuals' construction of experience.

Narrative and social constructionism

Social constructionists such as Henriques et al. (1984) and Gergen (1985) propose that the process of story-making (and hence self-making/sense-making) depends critically on the cultural resources which are available for quotation (Derrida 1977,

1978) and connotation (Barthes 1973), which will include particular forms of subjectivity and patterns of relationship. The term 'discourse' is often used in preference to 'language' or 'story' to indicate a meaningful network of identities, relationships, roles, duties, expectations, rights, and ways to express these, in order to indicate a more inclusive framework than 'language' might imply - i.e. words have their meaning within broader cultural frameworks. Like constructivists, constructionists are interested in the deconstruction of narrative, but tend to focus more on:

- the interrelationship between 'individual' narratives and the discourses and symbolic resources within a culture
- the social performance and functions of narrative (e.g. audiences and the circulation of stories)
- how new narratives are produced through joint action or co-construction, rather than the sense-making of the individual alone.

These theorists draw on Foucauldian writings (e.g. 1972, 1977, 1979, 1986) about the discursive construction of subjectivity, and Bruner's project (e.g. 1986, 1990, 1991) to develop a 'cultural psychology' including both narrative knowing and paradigmatic knowing. Bruner's work provides a bridge into Western thought for Vygotskian developmental psychology which theorises the development of the intramental through the internalisation of the intermental (Vygotsky 1962). The emphasis on cultural resources, quotation, and language has also led to the importation of meaning and methods from realms such as literary theory, linguistics, anthropology and analytic philosophy (Burr 1995, Potter 1996). For example, there are fruitful links with the psychophysical position of Wittgenstein (Hacker 1997, p. 4) and Bateson's 'ecology of mind' (1972, 1979), which view 'private experience' or classically 'mental' phenomena as manifestations of the patterns of interconnection between environment, culture, families and individual events and histories. That is, mind is both immanent and epiphenomenal across an ecology as a whole, not

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[1] E.g. *Journal of Constructivist Psychology*, *Journal of Cognitive Psychotherapy*, special issues on narrative approaches, 1994.

something contained within an individual but influenced by factors described as 'external' or 'other' in relation to the mind.

Postmodernism has provided a rich seam of concepts and practices. Postmodernism may be described as a position of 'incredulity to metanarratives' (Lyotard 1988), which places in question how 'taken-for-granted' or pre-eminent/dominant theories or cultural practices are constructed from others, teasing apart how claims to legitimacy are produced and noting the gaps and inconsistencies that are revealed in the process. Postmodernism incites a sceptical attitude towards claims of universal or general 'Truth', emphasising instead how knowledges are produced and validated in local and contingent circumstances.

The development of social constructionist stances within psychology does not simply represent an epistemological shift and the impact of postmodern analysis, but has also been driven by political and ethical concerns about social justice and inequality. For example, feminist critiques of family systems theory have been highly influential in the development of social constructionist 'third order cybernetic' therapies such as White's approach (White and Epston 1990, White 1995, 1997), while anti-colonialist and anti-racist critiques of therapy have fuelled the development of 'Just Therapy' (Waldegrave 1990). The distinctly modernist project of Marxist thought is another pervasive influence within much social constructionist writing (e.g. Callinicos 1989, Willig 1997, 1999). Experiences such as marriages, love, racism, family violence, poverty and child sexual abuse are clearly socially constructed, but none the less 'real' for that.

From this perspective, the stories an individual or family can tell about themselves and their world are not simply a product of their creativity and personal experience, but also reflect and reproduce the social world of which they are a part. Social constructionism shares the postmodern emphasis on textuality, but also emphasises the contextual nature of experience. This simultaneously points towards the richness of resources available for the construction of experience, but also (a) in a 'top-down' version of constructionism (Hollway 1989) indicates the constraining and constitutive nature of culture, including forms such as patriarchy, racism, rationalism and advanced capitalism, and (b) in a 'bottom-up' sense shows how each of us can be

understood as active substrates or sites for the propagation and transmission of these forms of cultural life (Foucault 1972, Dallos and Urry 1999).

Postmodern scepticism towards grand narratives need not be read as a nihilistic relativism and decadent amorality, but can instead be used to maintain curiosity about aspects of experience which are suppressed or omitted in accounts which are inevitably partial, and as a reminder of the tentative, situated and double-edged nature of our theories. Frosch suggests that postmodernism is not a gratuitous glorification of the plastic textuality of lives, but a pessimistic reminder of the difficulty in expressing and encompassing the human condition in language and confident theory:

> Postmodernism is not built on the argument that language is everything, that true emancipation occurs through story-telling. Instead, postmodernism demonstrates the insufficiency of language, the way in which all this narrativising is a defence against something else, something less easily pronounced, but more powerfully disruptive... (Frosch 1997, p. 93)

Following Edwards et al. (1995) and Davies (1998) I suggest that as practitioners concerned with effective interpersonal action and social change, counselling psychologists should not regard the inherent relativism of postmodernism and social constructionism as an 'anti-realist' position, but rather as a meta-level epistemology facilitating a further analysis and review of realism by taking one step back. Nightingale and Cromby (1999, Chapter 14) suggest that this is of value insofar as it may help us develop a critical realism (Bhaskar 1978, 1989) providing possibilities for ethical action.

Deconstruction

This term is often associated with Derrida who has developed a loose but complex project demonstrating a variety of strategies challenging essentialist philosophies (e.g. 1977, 1978). Deconstruction is a process which aims to identify and hence problematise the resources, categories and strategies which construct particular forms of reality (Willig 1999). It is not a way of taking things apart in order to show their 'true' inner meaning or mechanisms. Values are attached through our meaning making, and these rest on both the terms which are present in the text and also through their relationships with other terms which are not present. Deconstruction

involves an attention to that which is not spoken but is nonetheless required for that which is said to make sense. The unspoken may be something so taken for granted that it seems beyond question (e.g. white identity in much (anti) racist discourse), or may be something which is so hard to speak of that it can be studied only through its boundaries with other constructs.

Deconstruction may be applied in therapy to try to unsettle sedimented and problem-saturated descriptions of 'what I'm really like as a person', or 'the right way to grieve' (Fredman 1997), or to call into question taken-for-granted ways of construing experience. More radically, deconstruction may be called on to question our certainties about good professional practice, and to help us examine the complex interpenetration of the personal and the political (Rowbotham et al. 1979). When this form of analysis is applied in a reflexive turn to psychology as a social form (re)producing knowledge and power relations it is sometimes termed 'critical psychology' (e.g. Nightingale and Crombie 1999). It follows that the fruits of deconstruction will often be greater uncertainty, or the replacement of apparent simplicity with complexity. The value of this is that a desedimentation of existing meanings can allow space for new meanings and moral agency to be constructed (Derrida 1994).

Difference within the portfolio

Each section of my portfolio engages with narrative and deconstruction in a different way, and explores different aspects of my professional practice. The elements of the portfolio are concerned with increasingly radical uses of deconstruction, moving from an essentialist form of counselling psychology as an empirically informed natural science, towards a critically reflexive psychology. Each section addresses areas of clinical practice where casually relativistic approaches to 'restorying experience' might seem insensitive to the socially constructed but very 'real' issues involved; death and bereavement[2], physical and sexual abuse, and the palliative care of terminally ill patients.

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[2] See for example Seale (1998) and Edwards et al. (1995) for detailed discussions on the socially constructed nature of death.

The **literature review** uses the example of bereavement to indicate how certain psychological problems and the need for therapy may be understood as socially constructed narratives, and demonstrates how two different types of research (Stroebe's empiricist psychology and Walter's biographical sociology) may be used to deconstruct a dominant therapeutic narrative, the grief work hypothesis. Metaphors of narrative and deconstruction provide a framework for integrating research from other disciplines into the therapeutic work of a counselling psychologist, and linking empirical science with psychotherapy practice. An appendix provides three clinical examples showing how this constructionist research can be used to guide the use of deconstructive tactics in therapy with people facing bereavement.

The **case study** reviews the use of narrative deconstruction as a form of therapy in its own right. Whereas the literature review frames psychology primarily as a natural science, the case study suggests that therapeutic practice is a form of semiotic science. The case describes brief individual therapy in primary care with a woman who had been abused. In a reflexive turn the study also uses deconstruction to generate a double description of the case study itself, demonstrating how case conceptualisation and reporting is itself a constructive activity situated within discursive practices. This shows deconstruction as a reflexive tool for ongoing professional development.

The **research section** focuses on clinical supervision. Foucauldian discourse analysis is used as a deconstructive research methodology. The research offers an interpretive reading of clinical supervision in specialist palliative care services, exploring how discursive contexts shape the meanings of accounts of supervision. Whereas the literature review and case study imply that therapist and client exercise choices to 'use' or select some narratives rather than others (an essentialist form of psychology), my research section shifts attention away from individual intentionality to examine how actions and identities can be seen as produced and given meaning by wider social discourses and contexts.

Table 1 Varieties of deconstruction within the thesis

Component	Uses of deconstruction	Content/Focus	Modality
Section 2 Literature review	Deconstructing a dominant therapeutic narrative of bereavement and grief Deconstructive tactics within therapy	Constructionist perspectives on bereavement theory and therapeutic practice with clients facing bereavement	The review links positivist empirical research from clinical health psychology and qualitative socio-logical research (An appendix shows applications in therapeutic practice)
Section 3 Case study	Narrative deconstruction as a form of therapy (emphasising re-authoring) Deconstruction of the study as an aid to reflexive practice	Issues of physical and sexual abuse and child protection, with a mother of young children Partiality and bias within a therapist's account of a case study	Time-limited individual narrative therapy in primary care A critical review of my own construction of the case in the original case study
Section 4 Research study	Deconstruction as a form of research methodology Critical psychology: deconstructing mainstream psychology's focus on individuals	Clinical supervision, within the context of specialist palliative care services. Interpreting individual accounts in relation to wider discourses and contexts	Interpretative discourse analysis of individual interviews conducted with palliative care workers

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Section 2 Literature Review

Constructionist Approaches to Bereavement and Therapy[3]

> 'Grief' describes a pattern which recurs, with different variations, in the weave of our life. If a man's bodily expression of sorrow and of joy alternated, say with the ticking of a clock, here we should not have the characteristic formation of the pattern of sorrow or of the pattern of joy (Wittgenstein 1958, PI (II) i)

Introduction

This literature review examines the fit between emerging social constructionist perspectives in two different strands of bereavement research and developments in competence based constructionist psychotherapies, particularly the solution-focused and narrative approaches. My aim is to highlight areas of potentially productive overlap between these fields and illustrate how therapists working with bereaved clients could develop their practice in view of these developments.

My thesis as a whole concerns the uses of deconstruction in relation to a counselling psychology that is both contextually sensitive and textually sophisticated. This review uses deconstruction to unsettle a dominant professional narrative of bereavement processes, and suggests ways in which deconstruction may be used in therapy with people who have suffered significant loss.

Serious illness, death and bereavement may seem like challenging territory for therapy which aims to use language to re-author clients' experience to construct more satisfying lives. After all, although bereavement is a socially constructed experience (Edwards et al. 1995, Seale 1998), no amount of clever semantics can cheat death. Most cultures tend to have especially powerful narratives and conventions surrounding key life transitions such as births, marriages and deaths (Imber-Black et al. 1988, van Gennep 1960, Loudon 1966, Chapman 1983). Dominant professional narratives of bereavement are closely intertwined with lay constructions of

[3] An earlier version of this review was published in *Counselling Psychology Review* 13 (4) (1998) and 14 (1) (1999).

bereavement processes. Therapeutic attempts to enable individual/family flexibility and adaptation must take account of these.

Structure

The literature review has four main sections, and is supplemented by an appendix presenting three clinical vignettes involving some of the issues raised.

(1) I begin by reviewing the traditional 'grief work' approach to bereavement counselling which permeates much psychotherapeutic discourse about death and dying, and is deeply embedded within contemporary popular discourse concerning loss and bereavement.

Then I outline two significant research based challenges to this model developed in the 1990s:

(2) The 'Dual Process Model of Coping with Loss', an empirical scientific perspective researched by the clinical and health psychologist Margaret Stroebe

(3) The narrative perspective of the sociologist Tony Walter (bereavement as a process of (auto)biographical reconstruction)

Any literature review is necessarily selective and partial. Rather than survey a wider range of challenges to the grief work hypothesis, I have decided to offer a more in-depth examination of these two bodies of work. I felt it would be helpful to consider two different research strands to exemplify the diversity within constructionist work, and also to reduce the temptation to replace the grief work hypothesis with a new, 'correct' model, rather than illustrate the ongoing dialectic of practice and theory. Although Stroebe and Walter approach the topic of bereavement from different professional traditions and use different research methodologies, both offer theories drawing upon postmodern ideas which offer the potential to problematise or unsettle 'taken-for-granted' knowledge about bereavement derived from the grief work model.

(4) This final section reviews potentially fruitful connections between the constructionist bereavement research literature discussed in Parts 2 and 3 and recent constructionist approaches to psychotherapy.

The 'first wave' of psychotherapy consists of pathology-based therapies including Freudian therapies and biological approaches, while the 'second wave' refers to problem-oriented therapies such as the behavioural, family and cognitive therapies. 'Third wave' therapies such as solution-oriented/focused and narrative therapies assume that a focus on problems can obscure clients' resources, and so can be described as competence based therapies or 'resource models' (Hart 1995). Resource models of therapy stress the importance of harnessing client resources and making use of factors outside of therapy to help promote and underpin therapeutic change. From a narrative perspective, clients' resources include the full range of their lived experience besides that which features prominently in the initial account of the problem (Bruner 1986, p. 143). Narrative therapies in particular claim to de-emphasise therapist knowing and expertise, aiming to attend more to clients' stories and the contextualised position of therapy in wider social discourses.

The Appendix presents three short case studies involving the themes presented in the literature review, based on my own practice as a counselling psychologist in primary care and hospice settings[4].

Like other practitioners in the 'helping' professions, counselling psychologists must find ways to minimise gaps between theory and practice or find ways in which to use the distance between theory and practice as an energetic space for creative dialogue. From Freud onwards there has been a lengthy tradition within psychotherapy of using case studies and clinical anecdotes to communicate new ways to understand therapy. Casement (1985, 1990), Judd (1989) and Laing (1962) provide excellent examples of this tradition. Some therapists have extended this into work of independent literary merit (e.g. Laing 1970, Yalom 1989), including Stedeford's poetic explorations of death and loss (1994 pp. 129-34) developed from her work as a psychoanalyst and

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[4] Names and other identifying details have been altered to help preserve confidentiality.

psychiatrist at Michael Sobell Hospice in Oxford and the Gaelic poet Macmillan's 'notes in the margin' about his psychotherapeutic work with children (1992).

Such stories, anecdotes and metaphors are not simply demonstrations of theoretical points which have been made explicitly, but also provide important means to point towards therapeutic knowledge which is otherwise difficult to present in an explicit or didactic form (Polkinghorne 1988, 1992, Richardson 1990). Kvale (1996, Chapter 13) notes that case studies offer a basis for generalisation in legal and clinical fields, while Lovlie (1993) shows how cases can serve as a basis for learning about ethics. Donmoyer (1990) argues that stories in teaching provide a bridge between tacit personal knowledge and formal propositional knowledge, suggesting that therapists' case stories may facilitate useful connections between the singular and the general.

The judicious use of integrated case material may enable counselling psychologists to construct literature reviews which can be more easily related to clinical practice than conventional formats. Although Parts 1-4 can be read as a 'stand alone' literature review in their own right, I believe that their relevance for practitioners is enhanced when read in conjunction with the case material.

(1) Traditional modernist bereavement theory: the grief work hypothesis

Since Freud's seminal paper on 'Melancholia' (Freud 1917), mainstream Western psychotherapeutic approaches to understanding and facilitating bereavement processes have focused primarily on his notion of 'grief work' as a necessary means for the living to gain detachment from the dead, redeveloping their capacity to invest in and engage with new relationships in the present. In early Freudian psychoanalytic terms, grief work is a form of cathexis allowing the withdrawal of libido which had been invested in an object which is now lost. This libidinal energy then becomes available for the development of new relationships. Subsequent theorists have tended to revise this early hydraulic/energy metaphor in terms of internal object relations (Klein 1940), attachment relationships (Bowlby 1982) and the effects of internal models of attachment on psychosocial transitions caused by bereavement (e.g. Parkes 1988), but retain the emphasis on reviewing the internal world and revising this to separate from the dead as the core work of mourning.

Within this framework, bereavement therapy has aimed at facilitating or regulating grief work to help the bereaved to adapt to life without the deceased, aiming to bring the 'reality' of loss into the client's awareness as much as possible. Grief is seen as a period of work where reality is repeatedly tested against the bereaved person's internal assumptive world (Lewin 1935) until attachment is withdrawn. 'Pathological' experiences of bereavement are understood primarily as failure to face the reality of death and loss, either through avoiding grief work altogether as an immature form of defence against excessive psychological pain (Parkes 1986, Janoff-Bulman 1993), or by excessive 'rumination' when grief is experienced but not actually 'worked through'. As Parkes notes (1988), there are inherent risks of recursive entanglement, confusion and regress in this introspective process since the internal assumptive world that must be changed is itself a property of the mind doing the reviewing.

The development of staged models of grieving

The literature on grief work is extensive, although with a disproportionate emphasis in research studies on the bereavement of women and the elderly (Carverhill and Chartier 1996). Numerous variations and developments on this theme have been elaborated by workers such as Lindemann (e.g. 1944), Bowlby (e.g. 1980), Parkes (e.g. 1986) and Worden (e.g. 1991). A particularly significant elaboration has been the development of a staged model for the psychological process of dying persons as proposed by Kubler-Ross (1969, 1971, Copp 1998). Klass (1981/1982) argues that this provided an important symbolic framework for healthcare workers working with people who may be dying, offering these professionals a sense of order and progression to their existentially demanding work (unless of course this is disrupted by the refusal of other professionals and/or the patient to accept that the patient is dying, refusing to participate in what Seale (1998, p. 107) describes as the 'revivalist cultural script' of the 'happy death movement' (Lofland 1978)).

Kubler-Ross' staged model of dying seems founded on an almost transpersonal philosophy, perhaps in keeping with the popular Western counterculture of the 1960s and its emphasis on transcendence and mysticism. However, it closely resembles the staged models of grieving more explicitly linked with psychodynamic formulations of

loss and attachment, and like these also constructs dying and bereavement as progression, hard work, and achievements. Raphael (1983) provides an effective review of grieving stages identified by Gorer (1965), Parkes (1972) and Glick et al. (1974), showing how these map closely onto Kubler-Ross's stages. Some clinicians, most notably Worden (1991), have tried to link these primarily descriptive stages with the Freudian grief work hypothesis to create prescriptive frameworks for 'tasks' of healthy grieving.

Grief work as a normative model of intrapsychic structure and process

While most writers within this field recognise that there may be considerable variation in the presentation and pacing of grief and distress (i.e. the surface structure or signifier in structuralist terminology (de Shazer 1994 pp11-22)), the grief work hypothesis (like most of Freud's work) and associated concepts such as stages and tasks of grief, can be seen as a grand theory aiming at a description of underlying deep structures of intrapsychic process common to humanity. Such structuralist assumptions are shared with other therapeutic models commonly employed in bereavement work, particularly the person-centred therapies with their emphasis on a 'true self' and 'basic needs', and the therapeutic emphasis on helping clients make contact with and use 'what's really going on inside' (e.g. Klein et al. 1986). Although the focus and language of the therapeutic work in session differs between psychodynamic and humanistic practitioners, the agreement that there are universal and essential intrapsychic processes associated with bereavement has contributed to a lengthy period of remarkable consensus amongst bereavement therapists. (This is not to say that bereavement researchers and practitioners have been complacent about the adequacy or completeness of their theoretical formulations and intervention strategies, as Stroebe et al. (1994) remind us in a trenchant defence of classic work in the field against a controversial and influential article by Wortman and Silver (1989) which attacked what they described as prevailing 'myths of coping with loss'.)

This structuralist notion that there is 'a bottom to get to and that whatever is happening can be explained' (de Shazer 1994, p. 12) may have aided co-existence with medicine which has funded and housed much professional bereavement work,

given the dominant discourse of good diagnosis (and treatment of underlying pathology) which is both desired and empowering within that discursive field.

Death and palliative care can be seen as offering significant challenges to such medical discourse. While this may create cracks for new discourse to take root (e.g. regarding the care of the family and the management of emotion) and old ones to sprout anew (e.g. the care of the soul (IJPN 1997)), these may take root more firmly if they can draw sustenance from, and perhaps reinforce, the idea that it is possible to get at 'what's really going on' if we look and listen hard enough, and that there may be underlying certainties and meanings to hold onto even in the face of death. What is the meaning of loss, what does death signify? Within the realm of Western medicine, death may be akin to the hole at the bottom of structuralism pointed to by Lacan in 1953, signalling 'a constitutive lack at the core of language, a lack which marks the absence of a fixed anchoring point, the absence of a solid meaning for any term.' (Grosz 1990, p. 96). Such a hole can allow meanings to be poured in from new frames of reference, and/or for established meanings to leak away.

(2) Stroebe's critique of the grief work hypothesis

A grand theory with universal application, good predictive power and clear implications for effective clinical practice has much to commend it, if it works. Unfortunately, this does not seem to apply to the grief work hypothesis, as the clinical and health psychologist Margaret Stroebe and her colleagues have painstakingly demonstrated through a series of carefully researched empirical studies and reviews throughout the 1990s[5]. Stroebe does not claim that the grief work hypothesis is wholly wrong or lacks clinical utility for some clients in some situations. She suggests that the hypothesis might be most relevant for working with bereaved spouses showing particularly 'pathological' grieving, a population associated with much of the early clinical experience underpinning grief-work formulations - 'that is, the grief work hypothesis is most applicable to those cases for which it was originally developed by Freud' (Stroebe 1992, p. 38). However, she concludes that 'taken as a

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[5] Stroebe and Stroebe (1992), Stroebe (1992), Stroebe et al. (1992), Stroebe et al. (1993a), Stroebe et al. (1993), Stroebe (1994), Stroebe et al. (1994), Stroebe (1997), Schut et al. (1997).

whole, the empirical evidence reviewed... does not back the strong claims made by theorists and clinicians in favour of the grief work hypothesis. There are insufficient studies, there are methodological shortcomings, and there are inconsistent findings. Overall... the grief work hypothesis has neither been confirmed nor disconfirmed empirically' (Stroebe 1992, p. 27). Although the grief work hypothesis is modernist and medical and may well have provided an affirmative support for professionals in the sense described by Klass (1981/1982), it does not seem to be good science in the senses advocated recently by Legg (1997).

Particular concerns cited by Stroebe and her co-workers include:

- inadequate definition and operationalisation of terms
- overgeneralisation from client populations which are not demographically representative
- lack of cross-cultural validity - for example, grief work is not similarly valorised or even present across all cultures
- weak and contradictory evidence of effectiveness on patient outcomes from related clinical intervention
- overemphasis on intrapsychic processes and 'primary' consequences of bereavement (e.g. depression, anxiety, grief) rather than interpersonal processes and 'secondary' consequences such as role changes, lifestyle factors, etc. which may be better modelled and predicted by psychological theories of stress from health psychology
- neglect of the cultural and historical context - e.g. contrasting this Western modernist emphasis on 'breaking bonds' and letting go of the dead with a 19th century romanticist ethos, within which 'such breaking of bonds would destroy one's identity and the meaning of life' (Stroebe et al. 1992, p. 1205)
- questionable use of mechanistic metaphors for human functionality implying a need for people to 'recover from their state of intense emotionality and return to normal functioning and effectiveness as quickly and efficiently as possible' (Stroebe et al. 1992, p. 1206)

- lack of fit with empirical data on the way in which many bereaved people who are not apparently 'pathologically stuck' experience and manage their loss and ongoing life through holding dear, and even thinking more about, the departed dead rather than 'letting them go'. Stroebe and her colleagues suggest that 'to approach the therapeutic or counselling setting with a universalist (and more specifically a modernist) preference for breaking bonds is not only to undermine existing patterns of culture, but to throw into question the normalcy or emotional adequacy of an otherwise unproblematic segment of the population' (Stroebe at al. 1992, p. 1209)

Stroebe presents her evidence-based work as advocating openness to the diversity of possible bereavement processes and ways of managing this, both between individuals and between groups/cultures. In this sense, Stroebe's work is scientifically constructionist and postmodern, although Peskin (1993) has read her as arguing to replace a modernist model with a romanticist one (see *American Psychologist* 47 (1993)) for Peskin's comment and Stroebe et al.'s rebuttal).

Stroebe does develop a provisional new general model of coping with loss called the 'Dual Process Model' (DPM), but which contains considerably more space in which to account for variations in response to loss which need not be regarded as pathological (Stroebe and Schut 1993, 1994, 1995, Stroebe 1994, Archer 1999). In essence, she suggests that 'avoidance of grief work' (an unhealthy thing from the traditional perspective) can often be conceptualised more validly as attention to a 'restoration-orientation', a useful part of the process in its own right rather than simply constituting a break from the 'real' work of grieving ('loss-orientation'). The DPM suggests that there will be an oscillation between loss and restoration which may reflect (a) a healthy process related to an individual's readiness and need to engage with each aspect, and (b) interpersonal factors related to the needs of others in the social or cultural network, for example if one imagines that the DPM could apply to a family system as a whole with several members potentially occupying different positions within it at the same moment.

Stroebe suggests that the loss-orientation includes experiences such as grief work, intrusion of grief, breaking of bonds/ties and denial/avoidance of restoration changes. 'By loss-orientation we mean that a person is concentrating on, dealing with,

processing some aspect of the loss experience' (Stroebe 1997). The restoration-orientation would encompass attending to life chances, doing new things, distraction from grief, denial/avoidance of grief, new roles/identities and relationships. 'By contrast, [this is]... the dimension that has been given much less attention, and that has not been made explicit in bereavement research or in counselling... When a loved one dies, not only do we grieve for him or her, we also have to adjust to substantial changes that are secondary consequences of loss' (Stroebe 1997). This is consistent with previous work on bereavement as a psychosocial transition, but also emphasises the development of new roles, skills and relations as well as the losses incurred in a transition.

Stroebe proposes that 'positive emotional states are integral to the coping process itself. In other words, positive emotions can actually help one to cope with bereavement, they are part of the grieving process. They are not just 'offsetting' emotions that occur in relation to the cessation of an aversive condition' (Stroebe 1997). Importantly, she does not seek to identify the 'loss-orientation' with 'negative' emotions and the 'restoration-orientation' with 'positive' feelings, and equally she does not equate 'loss-orientation' with emotion-focused work and 'restoration-orientation' with problem-focused or more cognitive work. For instance, she suggests (Strobe 1997) that restoration-oriented coping with regard to a role which used to be the province of a deceased partner could involve trying to learn the skills lost with the deceased and/or working on one's fears about this.

Stroebe argues that different styles of cognitive processes can be applied to both orientations, with either positive or negative affect, and draws attention to recent work by Folkman et al. (1996) examining a large scale prospective study of the effects of caregiving and bereavement among partners of men with AIDS. Folkman et al. found that 'positive (re)appraisal' loss-oriented confrontation was helpful to the bereaved, but confrontation with negative affect relating to the period before the death led to poorer adjustment. Their research indicated that there were both positive and negative emotional experiences for the carers during the illness and bereavement phases, and that being able to find positive meaning in the stressful events related to bereavement could help reduce stress. Summarising the implications of the work of Folkman et al., Stroebe argues that 'this study suggests the need to focus on these

positive states of mind in addition to focusing, as in the past, on coping with distress' (Stroebe 1997).

Summary of key clinical points arising from the Dual Process Model

- Many bereaved people will oscillate between a loss-orientation, when they are reviewing and (re)experiencing aspects of their relationship and experiences with the dead, and a restoration-orientation, when they are attending to life chances, new roles and identities and 'moving on'.
- Oscillation is a natural, generally healthy process. Some complications of bereavement may be understood as a disruption or distortion of this oscillation, but therapists should be careful not to over-attribute variations in grieving patterns to psychopathology.
- Cultural, family and personal factors may influence the pattern of the oscillation, and will also influence the repertoire of activities and emotions which can be performed and experienced within the loss and restoration orientations. Bereavement is a culturally and historically situated phenomenon, not solely a matter of personal or family experience. This applies also to clients' and therapists' ideas of what is and is not abnormal or unhealthy, and what kinds of 'treatment' might be appropriate.
- Both loss and restoration orientations may be associated with negative or positive affect. There is some evidence that positively (re)appraising experience in the loss-orientation may be causally associated with lower levels of distress, while negative (re)construction (rumination, wishful thinking etc.) may lead to poorer outcomes.
- It may be important for therapists to attend to (a) the pattern of a client's oscillation, (b) the value of restoration-orientation, (c) ways in which positive (re)appraisal and reconstruction of loss experiences may be promoted - in other words, how some positive meaning can be located within the loss orientation.

These recommendations arising from the Dual Process Model clearly have strong clinical relevance for therapists working with the bereaved, or indeed with those facing death. However, Stroebe and her colleagues have focused mainly on model

building and testing. There is as yet little literature for practitioners presenting case studies and clinical frameworks to support the use of the DPM in counselling the bereaved, or link synergistically with recent developments in the therapies outside the field of bereavement work (Stokes' work on childhood bereavement through the Winston's Wish project in the UK (1997) provides an early example of the clinical application of the DPM in a therapeutic context). Stroebe and her colleagues have pointed to a largely unexplored territory for most bereavement counsellors.

Taking the DPM forward

As yet, the implications of the DPM model of bereavement for the understanding of the psychological processes involved in dying itself are still unclear. This would need careful conceptualisation of the meaning of 'restoration-orientation' for a dying person, which in turn requires a theorisation of the nature of the psychosocial (psychospiritual?) transition involved in death from the dying person's perspective. Although this has been the subject of considerable reflection in Buddhist psychology (e.g. Rinpoche 1992, Fremantle and Trungpa 1975, Rinbochay and Hopkins 1985, Mullin 1986), studies of near-death experiences (e.g. Lorimer 1990, Ring 1982, 1985), and transpersonal psychology (most notably Wilber (e.g. 1977, 1980, 1991, Wilber et al. 1986) but for a broader review see Rowan (1993)), this aspect of the human condition is not well theorised within mainstream 'lifespan' psychology (Copp 1998).

Seale (1998, p. 107) suggests that there are considerable epistemological problems in reconciling scientific empiricist studies of death and dying with other important forms of experience and knowledge in this domain, and argues that the empiricist critique of Kubler-Ross's stages by Stroebe and others (e.g. Wortman and Silver 1989, Littlewood 1992, Corr and Doka 1994) may be misplaced. Some of my earlier comments about the value of case studies and narratives may apply to the investigation and communication of this area. Stories may speak to us quite differently from objective research (e.g. Kubler-Ross 1978, Moore 1996). However, Walter (1994, p. 127) observes that many works within the genre of deathbed / bereavement 'pathography' are written by middle-class white females, and cautions that they should be read as highly culturally specific.

(3) Walter's model of bereavement as (auto)biographical reconstruction

The sociologist Tony Walter (e.g. 1991, 1994, 1996) has also developed a new model of grief to challenge the hegemony of traditional approaches to understanding and working with bereavement, which diverges in some significant aspects from Stroebe's Dual Process Model. Walter's work is founded on sociological and narrative investigation (including the analysis of his own personal experiences of bereavement), rather than empiricism, and he does not attempt to locate his own work within an empirical scientific tradition in the same way as Stroebe does. He argues that 'an autobiographical approach is appropriate because my proposed model sees bereavement as part of how individuals construct their biography: autobiographical data is therefore highly relevant' (Walter 1996, p. 9).

Walter argues that contemporary bereavement literature and professional practice has not simply overemphasised the 'loss-orientation' of 'breaking ties' with the dead and 'confronting loss', as Stroebe has argued. Walter agrees that bereavement models and processes need to be understood in their cultural and historical context. However, he argues strongly that bereavement need not be about detaching from the dead and 'moving on' in life (whether through grief work or a Stroeberian oscillation shifting between loss and restoration orientations). Instead, he suggests that professionals have been too quick to discount the possibility of maintaining meaningful relationships with the dead, of moving on in life with the dead as a part of our lives. Sociologically speaking, his work can be situated within a 'revivalist' discourse (Walter 1994, Seale 1998, Chapter 5) that attempts to place value and focus on the process of death and bereavement within wider culture, sometimes through a contrast with apparent 'atrocity narratives' about uncaring medical professionals seeking to hide or conceal death as a private or even shameful experience rather than an important aspect of communal life (e.g. Glaser and Strauss 1965, 1968, Sudnow 1967, Kubler-Ross 1969, p. 9).

Walter proposes that 'the purpose of grief is therefore the construction of a durable biography that enables the living to integrate the memory of the dead into their ongoing lives; the process by which this is achieved is principally conversation with others who knew the deceased. The process hinges on talk more than feeling; and the

purpose entails moving on with, as well as without, the deceased' (Walter 1996, p. 7). Walter does not mean by this a comforting but illusory kind of sense that the deceased is still alive or present which is acknowledged as a 'healthy' feature of mourning in classic bereavement texts, providing this is temporary and gradually fades away from the autonomous individual who can then leave the dead behind and be open to new bonds and relationships. Rather, he suggests that the deceased should be allowed a valuable, lasting place within our lives.

Walter cites sources such as the Shona tradition in which the dead person is seen as being lost then re-found, anecdotal accounts of bereaved people who enjoy holding onto their memories strongly and may even find these strengthening, and work by Marwit and Klass (1995) which found four common roles for the deceased among students they interviewed: (a) as a role model, (b) giving guidance in specific situations, (c) clarifying the student's values, and (d) as a valued part of the student's biography.

Walter suggests that this need or desire to hold onto the dead has often been acknowledged within the 'classical' bereavement literature, but only as a minor theme downplayed in favour of letting go and moving on, and suggests that this reluctance to make room for the dead reflects the secular and individualistic nature of late 20th century Western society[6]. Paradoxically, however, he suggests that this increasingly self-referential nature of identity in which we experience ourselves as largely detached from traditions, family and places (see Giddens 1991), and so have to continually (re)construct our identity, makes it all the more important for us to find ways to hold together our experience of ourselves and the dead lest another thread of our identity unravel. In other words, we can understand the death of one who knew us not just as the loss of a friend/lover etc., but also as the possible loss of one of the underpinnings of our personal identity and self-narrative.

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[6] Compare this with the traditional continuation of a relationship with the dead in the religious rituals of Japan as described by Yamamoto: 'The ancestor remains accessible, the mourner can talk to the ancestor, he can offer goodies such as food or even cigars. Altogether the ancestor... remains with the bereaved.' (Yamamoto 1970 p181).

Walter does not set out a new theory of bereavement counselling. Rather, he suggests that therapy with a stranger who did not know the deceased is a poor second-best to talking with others who knew the dead person, to enable a triangulation-like process of sharing fragments of narrative about the dead, checking and negotiating accounts of the dead and their meaning in the lives of the living in ways that can create tolerable and durable narratives of self-in-relation-to-the-dead to be carried forward. Walters describes this almost as a kind of 'reality checking' given impetus by our anxiety in a fragmented postmodern world where roles are not fully fixed and predictable, so we cannot retain the dead simply by memory of their public role, relationship, occupation etc.

This interpersonal and communal model of bereavement as a public act of constructing and sharing an account of the deceased differs markedly from (but does not exclude) the intrapsychic presence of the dead in internal dialogues (Stroebe et al. 1992, p. 1210) between the survivor and a kind of 'social ghost' (cf. Gergen 1987). Walter comments in relation to a personal bereavement that 'what helped me were not 'internal dialogues with a deceased person', but external dialogues with others who knew her... This was not social support for an intrinsically personal grief process, but an intrinsically social process' (Walter 1996, p. 13). Walter stresses that his model is based on narrative rather than emotion, the social construction of a biography in language rather than catharsis or 'working through' of feelings, and speculates whether his model might perhaps be particularly suited to bereaved men rather than bereaved women[7].

Summary of key clinical points arising from Walter's biographical model

- Like Stroebe and her colleagues, Walter argues that bereavement processes (and hence interventions needed, if any) will vary across cultures, families and individuals, and suggests that monolithic models of grief are inappropriate in a postmodern era.

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[7] A suggestion which contrasts with an apparent advantage of 'emotion-focused' counselling over 'problem-focused' counselling for bereaved men found by Schut et al. (1997).

- Walter speculates whether 'the degree to which the dead and the living had constructed a shared worldview and a shared understanding of their respective biographies' (Walter 1996, p. 21) may be an important factor in considering the applicability of different models of grieving.

- Walter suggests that the bereaved should feel able to retain their dead, potentially in a lasting rather than temporary relationship, but suggests that given the zeitgeist promoting the need to 'let go' of the dead it may be important for professionals or those with authority (e.g. the officer presiding at funeral services) to reassure and give permission for this.

- Walter suggests that there may be an increasing need for the living to find ways of 'checking' or researching who the dead was (and hence reinforcing and reconstructing their own sense of identity) in communities which are particularly fragmented or dispersed. 'Trying to grasp the reality of the deceased being gone but yet being here, and doing this through continually monitoring that reality by talking to those who knew her, captures the model of grief presented in this article' (Walter 1996, p. 19).

- He argues that this construction of a durable biography is likely to be most effective as a shared social process with others who knew the dead rather than with the counsellor, and so recommends that professionals should support such contacts outside therapy.

- Walter suggests that talking about the deceased may be a more helpful approach to bereavement support than expressing feelings.

(4) Stroebe, Walter and resource model therapies in postmodern context

Taken together, the recent constructionist work of Stroebe and Walter offers a substantial challenge to established Western psychotherapeutic practice with respect to alleviating the distress of those who have been bereaved. This challenge has not developed in cultural isolation, but is contemporaneous with other postmodern

challenges to grand theories and the construction of totalising knowledges[8], as authors such as Foucault (1965) have progressively cast doubt on the basic underpinnings of claims to universality, and have increasingly drawn our attention to ways in which 'patterns of action, including their meanings and significance, are at least in part, socially constituted, and thus subject to historical and cultural change' (Stroebe et al. 1992, p. 1205).

Postmodernism can be viewed as an entirely 'negative' project (e.g. Leupnitz 1992) which destroys our old understandings and guides without any replacement - this is undeniably an uncomfortable position for those who see themselves as members of the 'helping professions'. However, it may be more helpful to read postmodernism as a critique to 'make us more modest and anxious about our knowledge' (Pocock 1995a, p. 47), a stance which should lead us to listen carefully to clients to see if our understandings fit what they need, to regard theories and methods as provisional and locally (in)validated in a given socio-cultural, family, historical or relational context rather than universal. Legg (1997) reminds us that this irreverence to knowledge claims is already the hallmark of scientific epistemology following Popper (1963), and reminds us that science may still be an effective servant in a postmodern era if we use it to help us uncover and use 'better stories' (Pocock 1995b). Stroebe's scientific studies suggest that the 'grief work' hypothesis does not fit well with the available evidence, does not help us predict future outcomes very accurately, and seems more limited in socio-cultural scope than previously imagined.

A parallel reading of this recent bereavement research with contemporary developments in postmodernist narrative and solution-focused therapies may offer bereavement professionals some guidelines for temporary and provisional mapmaking of the localities they explore with each client. My intention here is not to offer a comprehensive review of the rapidly growing literature in this 'third wave' of psychotherapy, but rather to promote some cross-fertilisation between these blossoming fields. Currently, this is very limited. The brief review that follows may

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[8] Although it can paradoxically be argued that postmodernism or social constructionism are themselves new grand narratives (e.g. Lowe 1991).

be read alongside the clinical vignettes provided in the Appendix which offer more extended illustrations of some possible connections.

Stroebe and Walter make extensive reference to the established psychodynamic, humanistic and cognitive therapeutic traditions in bereavement work in developing their models, but to date have not drawn upon the narrative and solution-oriented psychotherapy literature at all. For example, there are no references in their work to White's early (1988) narrative therapy paper on therapeutic methods for reincorporating a lost relationship back into a client's self-story, although his arguments seem highly compatible with Walter's model of bereavement as autobiographical reconstruction, and White argues against a normative staged model of grief work. Both narrative therapy (e.g. White's use of 're-membering' practices (1997)) and the solution-focused tradition (e.g. Furman and Ahola 1992) emphasise the importance of communal connection and reconstructive conversations with non-therapists, but again this is not acknowledged in Walter's work.

Similarly, Stroebe does not draw upon any of the solution-focused therapy literature in her re-evaluation of 'grief avoidance' as a potentially healthy phase of restoration-orientation, although de Shazer's (1984, 1985, 1988, 1994, de Shazer et al. 1986) emphasis on client competency and 'resistance' as a conceptual error on the part of the therapist seem to offer a useful framework for working with bereavement in the Dual Process Model. More broadly, although Stroebe has collaborated with Gergen in some of her work, who in turn has been an important influence on the development of social constructionist therapies (e.g. MacNamee and Gergen 1992), Stroebe has not included constructionist therapies in her empirical reviews and trials.

Equally, systemically oriented therapists have previously noted, but not remedied, a lack of specific focus in family therapy and family systems literature on loss and death. Walsh and McGoldrick (1991, Chapter 1) suggested that this may be related to the 'here-and-now', behavioural-transaction focus of the strategic and structural therapies, but the neglect seems to be continuing in the narrative and solution-oriented therapies birthing from the older systemic schools, with two strong recent exceptions (Fredman 1997, Sutcliffe et al. 1998). Dallos and Urry's analysis (1999) of the flaws of second order cybernetic approaches in systemic therapy indicates a possible reason,

that much contemporary systemic practice still rests on a relativist assumption that problems can be solved by changing beliefs. From a critical realist perspective (Bhaskar 1978, 1989), this can only ever be a partial solution to loss by bereavement, since personal realities are constructed from and in relation to the potentialities offered by the wider social and material context (Willig 1999).

Conclusion

Counsellors working with bereavement need to listen carefully to ensure they are speaking the client's language. Although most practising therapists know this well and have sought to work with their clients sensitively, the predominant readings of the established bereavement literature have consistently emphasised 'working through grief' as the main purpose and objective of therapy (Raphael and Nunn 1988). This may mean that therapists of any orientation working collaboratively with their individual clients may at times feel that their practice is at odds with 'the literature'. This is of course a valid reason to review practice, but also a good reason to review the literature and theory.

This is not an argument for throwing the baby out with the bathwater. Western therapists would have to be peculiarly unempathic not to appreciate the emotional impact of loss through death and the essential place for grief in bereavement processes. However, it is a claim that there are many different ways of working with and responding to bereavement, which need not centre on confronting negative experiences of loss. The empirical work of Stroebe and her colleagues, and the sociological perspective of Walter are of great value in helping the field develop greater range and flexibility in understanding and working with bereavement, and highlighting avenues for further investigation.

Recent theoretical formulations in the bereavement field invite an exchange of ideas and practice with other contemporary developments in the constructionist therapies, particularly the narrative and solution-focused traditions. This is not an argument for a wholesale change of therapeutic allegiance or method by practising therapists, but rather a suggestion that an awareness of some of the ideas from therapies specifically developed as 'resource models' may serve as an additional lens (Hoffman 1990)

through which therapists may view their current practice in order better to identify and amplify aspects of their practice which already harness extratherapeutic factors, wider social discourses and networks, and the client's own contributions to change and resilience. The last half-century of psychotherapy outcome research (Miller et al. 1997) emphasises the importance of this over matters of therapeutic method or technique. The work of Stroebe and Walter is particularly distinguished and helpful in this regard in its attention to the actual experience of the bereaved over and above the formulations of professionals, foregrounding the actual lived experience of those living with loss rather than theory.

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Appendix Constructionist Approaches to Bereavement and Therapy

Clinical applications of the work of Stroebe and Walter in competency oriented therapy with three bereaved clients

In the main body of my literature review I outlined some ways in which recent constructionist work on bereavement by researchers such as Margaret Stroebe and Tony Walter poses a significant challenge to traditional Freudian-derived formulations of bereavement processes, which have tended to stress the importance of 'letting go and moving on' by disinvestment from the deceased person through grief work. Stroebe's work suggests that there is a need to focus on restoration tasks as well as on loss and grieving, and highlights the importance of 'real world' stressors and tasks (e.g. paying bills) as well as intra-psychic processes. Both Stroebe and Walter challenge the traditional emphasis on 'letting go' of the dead. Walter argues that bereavement may be better understood as an essentially interpersonal process of narrative reconstruction rather than an intrapsychic process of emotional reconfiguration. In this Appendix, I offer three case examples to show how perspectives from this recent bereavement research may fruitfully cross-fertilise with contemporary developments in constructionist therapies, such as the narrative and solution-focused models.

Resource models of psychotherapy emphasise client skills and competence given the constraints of their context, and downplay the expertise of the therapist. The therapist assumes that clients are the expert on their own lives and the way problems have affected them, and are their own best resource in dealing with their situation. Consistent with this, I ask some clients if they will allow me to use a part of their story (with confidentiality protected) to help others who are facing some similar problems. As well as validating client expertise and partially redressing some of the power imbalance facing all clients designated as 'in need of help', such a request may have the effect of 'normalising' the client's situation (i.e. the client is not totally alone in experiencing such difficulties).

These vignettes are based on my own professional practice with bereaved clients in primary care and hospice work. Each vignette illustrates the application of themes

from narrative and/or solution-focused work, with discussion to link this with the recent constructionist developments in bereavement theory presented in the body of the literature review. Although each client reported some value from the counselling work undertaken, I make no claim that other approaches would be less effective. My intention is simply to extend the breadth of therapeutic options available to therapists working with bereaved people.

Case 1: Andrew - Fruitful explanations[9]

Andrew (54 years) was bereaved when his wife Ada (52 years) died of lung cancer a year after diagnosis. The nurses involved in the final weeks of her care were struck by the apparent lack of communication between the couple, and Andrew's increasing anger and desperation directed at the nursing team, usually centred around demands to 'build her up' by making her eat and drink more, and to make her 'get up more'. As Andrew's insistence had mounted, so Ada had seemed progressively more withdrawn and passive, barely communicating. Ada spent most of her last month in the hospice, but died at home during a weekend visit arranged at her husband's request.

Andrew asked to meet me a month after Ada's death. He described himself as bitter and guilty, 'lost' and 'quite empty' inside. He found himself lying awake each night angry that his wife had 'not been willing to put up more of a fight', and thinking repetitively how rejected he felt that she had apparently cut herself off from him towards the end of her illness. He felt she had squandered the opportunity to have a little more time with him by not making more effort to eat, talk and walk.

They had been married for 23 years with three children aged between 14 and 22. He described the marriage as 'a good one, but with its ups and downs like anyone's', with particularly rocky patches when there were money troubles and when Ada had an affair. Ada had managed a small business while Andrew had worked part time for the business and part-time in building work.

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[9] Names and some other identifying details in each vignette have been changed to help protect confidentiality.

Andrew seemed most concerned to find a way to 'come to terms with' his wife's rejection of him in her final weeks. He felt that his difficult relationships with nursing staff had stemmed from frustration at what he saw as the worsening relationship with his wife. He alternated between blaming himself, then her, for not being able to 'get through to each other somehow - it was just such a waste.'

In terms of Stroebe's Dual Process Model[10], Andrew was principally oriented towards loss rather than restoration, with strong elements of negative (re)appraisal of loss and some rumination, rather than any positive (re)construction of the loss (Folkman et al. 1996). Andrew also worried that he should be 'crying more, not angry like this' - this could be seen either as some 'avoidance' of grief, or as the normative and potentially oppressive influence of a dominant discourse on how one is 'meant' to feel after a bereavement (cf. Walter 1996 p. 20).

Competence oriented therapies take client goals seriously, and work to help clients achieve these. Of course this is not unique to psychotherapy's 'third wave'. Forty years' outcome research demonstrates that across all therapy orientations results are better when client goals are accepted at face value and guide the therapeutic intervention (Miller et al. 1997 p. 105). The difference between 'resource model' therapies and other schools lies in the extent to which this is an explicit part of the therapeutic frame, rather than a matter of individual therapist preference, style and empathy.

Andrew's main aim was 'to make sense' of the relationship between him and Ada in her final weeks. I accepted this goal of making sense (rather than uncovering 'truth') from a stance of seeking 'fruitful explanations' (Furman and Ahola 1992 p. 74) which minimally attribute blame and shame. Some stories about events provide more satisfying accounts of lived experience and 'fit' better with other stories about ourselves which we value, while other stories seem more restrictive or invalidating. Resource models emphasise harnessing client resources and making use of factors outside therapy to help promote and underpin therapeutic change. From a narrative perspective, clients' resources include the full range of their lived experience besides

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[10] See main text of literature review for references.

that which features prominently in the initial account of the problem (Bruner 1986, p. 143). The work of Stroebe and Folkman and their colleagues suggests that this notion is not simply theoretically attractive but has empirically validated application to bereavement work.

The therapy was based on a stance of curiosity (Anderson and Goolishian 1992 p. 29) to generate possible explanations. The work included some normalisation (e.g. speculating about reasons why other couples might not communicate closely in similar circumstances), seeking analogies with other times in their marriage, and searching for 'exceptions' (de Shazer et al. 1986) or 'unique outcomes' (White and Epston 1990), that is, times during the illness when there had been closeness and communication rather than a sense of rejection.[11]

Some possibilities which we created over four fortnightly sessions included:

a) Ada may have been weaker than Andrew had realised, and may have been 'trusting' Andrew to take on the responsibility of dealing with the professional team. Although Andrew felt he had not discharged this very effectively, the idea that Ada might have been trusting she was 'in safe hands' rather than rejecting was very touching to Andrew. He had worried whether he had done the right thing 'bringing Ada home to die' since she had not expressed a view, but from this perspective Ada's view could be seen as an unvoiced statement that 'I trust Andrew's judgement'.

b) Ada had not seemed to want to talk much about her prognosis, and 'tended to avoid things anyway'. Andrew wondered whether she may have been trying to protect herself from difficult conversations in general, and avoid testing the reality of declining physical capabilities, rather than specifically rejecting him. Walter stresses the potential value for the bereaved of talking with those who also knew the deceased to help (re)construct their understanding of who the deceased was, as

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[11] De Shazer and White go to some lengths to draw theoretical distinctions between these apparently rather similar terms. Interested readers may wish to review de Shazer and White's commentaries in their respective chapters of Gilligan and Price (1993), and Hart's (1995) paper examining some of the motivations driving their emphasis on their differences rather than similarities.

a way of firming up a socially constructed reality, rather than a purely individualist intrapsychic process. I asked Andrew what the nursing team had thought about this. He recalled conversations he had had with two nurses who had shared some of their own frustration about communicating with Ada.[12] While he still wished he had communicated better with Ada, this alleviated his sense that she had rejected him personally, and reframed Ada's apparent passivity as a way of caring for herself. Andrew speculated whether his anger towards staff might have been a way of 'getting the feelings out' without unsettling Ada - a caring way of respecting Ada's desire not to talk.

c) Andrew recalled two episodes a few years previously when Ada 'took to her bed' for a few days - 'almost had a nervous breakdown really', when there had been financial difficulties in her business. Making this connection to a previous pattern of coping with stress outside the relationship, and recalling his frustration then at his powerlessness to 'sort things out for her' implied that there had not been an irreparable deterioration in their marriage as she was dying, but rather Ada was responding to extreme stress as she had before. Andrew recalled that Ada was grateful after these episodes that he had 'kept things going'. He remarked: 'it's what you sign up, isn't it, for richer for poorer, for better and for worse'.

Each of these possibilities held some potential for loss-oriented processes to contain more positive affect and attributions leading to more satisfying (re)construction of the bereavement. This work was not about encouraging Andrew to 'look on the bright side', since each explanation held considerable potential for sadness, pain and regret, and of course none could 'make good' the loss. However, neither was the process a primarily emotion-focused encouragement of the expression and working through of grief as traditional bereavement counselling promotes. Our discussion also touched on more self-critical or angry hypotheses (e.g. concerning the affair, and blame about

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[12] An example of how professionals may help families by being 'real' about their own experience of caring. While it is common sense to avoid burdening relatives with the professional's difficulties, there is also value in being careful not to isolate the relatives' experience from that of others - this can be seen as a normalisation and validation of the relatives' experience.

delays in initial diagnosis), but these did not constitute 'news of a difference' (Bateson 1972) since Andrew already ruminated over these nightly.

I explored with Andrew who else outside the therapy might be able to help 'make sense' of his relationship with Ada during her illness. In addition to recalling the 'social ghosts' (Gergen 1987) of the nursing team, he also identified his three children as others who might help him 'look over' some of the possibilities we had considered. Previously he and the children had talked 'very little about mum' since the death, with Andrew not wanting to upset them further and not knowing what to say. This exploration is consistent with Walter's recommendation that the bereaved may benefit from opportunities to talk with each other to (re)construct a meaningful and durable biography of the deceased, and may need 'permission' of some sort to commence this. Further, therapy models emphasising client resources and the client's contribution to therapeutic change stress the importance of attending to and amplifying extratherapeutic factors.

Andrew talked with his children, which led to some external validation of (b) in particular, but also made him more aware of the concerns and dilemmas currently facing the bereaved children. He chose not to explore (c) or other hypotheses bound up with Ada's affairs with the children. Our final two sessions focused more on the future and the challenges ahead for the family. This 'future' orientation involved oscillation between loss- and restoration- orientations, as Andrew alternated between grieving over the future-that-might-have-been with Ada, and planning for the new-future. A future focus is a major part of the solution-focused approaches, working from an assumption that change is not only possible but inevitable (de Shazer et al. 1986) whilst aiming to break overall goals down into smaller steps (George et al. 1990 p. 10).

Andrew had not settled on a single 'story' when we agreed to stop meeting, but felt he was able to see the illness experience as more connected with the rest of his life with Ada, was less sleepless and angrily self-blaming, and was becoming more engaged with some family finance issues which he felt would be 'upsetting but manageable'. Andrew was told that he was welcome to make contact again if he wanted. A competency orientation constructs therapy as a resource to be used flexibly, rather than a complete 'curative' treatment to resolve all issues at once (Hoyt 1995 p. 78).

Case 2: Anna - Negative restraint and the past as a resource

Solution-focused therapy (e.g. de Shazer 1985, 1988, de Shazer et al. 1986) assumes that existing alongside but independently of problems and the belief/behaviour patterns fuelling these, 'the client already has in place one, or many, solution patterns that are already effective in diminishing, limiting and restricting the problem' (George et al. 1990 p. 17). Helping clients to identify and harness or amplify such solution or coping resources seems consistent with the important place of the 'restoration-orientation' in Stroebe's Dual Process Model of bereavement.

De Shazer's language of 'solutions' and 'miracles may seem insensitive to many bereaved clients (or counsellors).'[13] Often the only solution or miracle that can be imagined will be the return of the dead. Purist solution-focused therapists pay minimal attention to 'problem patterns' beyond sufficient acknowledgement of clients' common need to 'tell the story' to help form therapeutic rapport (Furman and Ahola 1992 p. 73). White's narrative therapy (White and Epston 1990) may seem more appropriate, since it acknowledges the role and significance of problem(s) in people's lives, concentrating on mapping the relative influence of the problem over the person contrasted with the relative influence of the person over the problem.

Narrative therapies assume that clients' lived experience is richer than any one self-narrative can describe (Bruner 1986). Narrative therapists aim to work with clients to help to free them from a particular 'dominant story' by uncovering and co-constructing alternative stories which may have been 'subjugated' beneath the dominant narrative. This may mean talking with clients about apparently problem-saturated accounts, listening curiously for times when the problem hasn't been there (unique outcomes/exceptions) or exploring issues of 'negative restraint' (Bateson 1972 p. 399), asking what prevents/prevented the problem from being even worse.

Anna was a 58 year old woman with a problem-saturated dominant narrative about her life. She had been in a very stormy marriage for about 37 years before her

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[13] To help clients elaborate a vision of the future with more room for hope or change, the 'miracle question' asks clients to imagine how their life would be different if their problem(s) miraculously vanished while they slept - see de Shazer (1988).

husband died suddenly of a stroke three years before I met her. The family history was complex but unsettled, with many unresolved feuds which meant that Anna's son had refused to speak with her for the last six years, while her daughter communicated sporadically by letter. Anna had apparently taken overdoses on several occasions during her 40s, with a compulsory admission to a psychiatric hospital. When I met her she had several serious health problems including cancer with an uncertain prognosis, and felt depressed. She was on anti-depressants and under review by her GP and psychiatrist, but felt that she 'wasn't able to manage on her own', and was distressed to find herself thinking sometimes about killing herself, although without planning or intending to carry this out.

Anna's difficulties could be viewed through many lenses besides those of bereavement difficulties. However, at our initial meeting Anna framed her problems in terms of being unable to accept her husband's death, feeling extremely bereft and lonely without him despite the turbulence of the marriage. Viewed through the Dual Process Model, Anna seemed stuck in a very angry and negative loss-orientation. Consequently, it seemed appropriate to conceptualise the therapy as helping Anna move more towards a restoration-orientation from a very stuck loss-orientation. An alternative formulation for the therapy might have been to help Anna reappraise the loss with more positive affect, but this would not have been as consistent with Anna's stated goal (and seemed a more daunting task given the apparently very unsatisfactory nature of the marriage).

Where there is an extremely problem-saturated dominant narrative about the past, there must also be alternative stories that could be told about survival. How had Anna managed to cope on her own for three years without harming herself despite her despair? How was it that despite her husband's absence as a mediator between her and their children she was still in touch with her grandchildren? How come things weren't worse? Exploring these questions with Anna, combined with attempts to normalise and contextualise her situation in relation to other widowed women of her age seemed to help Anna become less acutely distressed and banish the thoughts/fears about harming herself. Anna continued to describe herself as depressed, and felt that her sporadic attempts to renew contact with her son didn't work and made her feel worse, but decided that nonetheless she wanted to keep trying. Rather than treating

this as 'resistance', we worked with this as evidence of her resilience and determination to keep going even against great odds (de Shazer 1984).

Anna was able to identify some resources which had sustained her over the years, such as her Christian faith. She began to include herself in her evening prayers which she had previously phrased only for her family and deceased husband (i.e. attention to restoring herself, as well as to those she had lost). However, perhaps her most useful (re)discovery was her memory of how useful she had found it many years ago when a chaplain had told her shortly after an overdose that 'nothing lasts'. Anna found it helpful to remind herself of this on days when she was feeling particularly low, as she felt it applied to her mood, her loneliness, her illness and her separation from her husband.

Far from wanting to let go of the dead, Anna's wish was more consistent with that identified by Walter (1996 p. 11) among elderly widows to be reunited with their spouse in heaven. While this could be seen as a further risk indicator regarding suicidal possibilities, it also constituted a kind of hope for Anna, with the idea of 'nothing lasts' pointing the way towards reunion without a need for her to hasten this. Anna discovered that she reminded herself of this on days when she was feeling very low, but forgot to do this on days when her mood was a little better. This discovery enabled us to become curious about what made some days better than others (e.g. speaking with an elderly neighbour, managing some light house cleaning), using this curiosity as a search for 'exceptions' to the problem, and as a means to focus and build on change (e.g. Kral and Kowalski 1989).

The aim of therapy was not to change Anna's view about the misery of her past or deny her current suffering, but to highlight how the problems she experienced had proved or even helped create resilience. Empathic care must be taken in such an approach to avoid invalidating the client's suffering or even seeming to approve of problems. As Furman and Ahola put it, 'however strong a bone may become from recovering from an accidental fracture we do all in our power to protect ourselves and others from such injury' (1992 p. 37).

Case 3: Linda - Building bonds with the dead

Linda (45 years) asked for counselling nine months after her father's death from cancer. She explained that she and one of her brothers were very angry about the elder brother's lack of involvement during their father's illness, and their frustration that he was blocking the choice of a headstone for the grave. Linda alternated between a fear and a desire that 'it will all come out into the open, how we all feel about him', at the graveside on the anniversary. Linda explained how her father had 'held the family together', and with his death it felt like the family was 'falling apart'. Linda felt lost, confused and isolated from her brothers and her mother, who seemed 'to have lost interest' in her.

I asked Linda what sense she had made of this so far, suggesting that she had probably already been thinking very carefully about this difficult situation. Approaches emphasising client competency stress the importance of attending to (and then amplifying) possible 'pre-session change' (Weiner-Davis et al. 1987 p. 306). This is one way to down-play the contribution of therapy to change, an important theme given that self-efficacy research predicts that clients attributing change to their own efforts are more likely to maintain such efforts in the future (Bandura 1977, 1986). Asking Linda what sense she had already made was intended to convey my belief that she had the capacity to construct meaning herself, and also to invite possible alternative constructions of the loss. It is more parsimonious to try to build on constructions and changes already seeded by the client rather than create brand new understandings.

Linda explained that she felt things were particularly difficult for her since she was an adopted child (unlike her brothers), and knew that her father was the one who had 'picked her' from a children's home when she was 11 years old. She felt her (adoptive) mother had never really wanted her, and with her (adoptive) father dead it was as though the adoption had been 'cancelled, like being taken back to the shop as a reject'.

In our second session we constructed a genogram of Linda's family. She supplied a wealth of detail about her 'care-taking' (i.e. adoptive) family, but knew very little

about her biological family. Linda said she had tried a couple of times in the past to find out more but without success. She had been born in Manchester to a young unmarried Catholic woman, then spent the first four years of her life in a special hospital unit for children with physical disabilities, and was then 'given up' by her mother to a children's home run by nuns. Linda had no further contact with her mother. She received an anonymous letter telling her to mind her own business when she tried to send a message to her mother through the religious foundation when she was 15.

The aspect which struck Linda most forcefully as we viewed the genogram together was the way in which she seemed right at the edge of the family, in a very lonely position, with an emptiness to one side of the page where her biological family belonged. It seemed that her experience of loss through her (adoptive) father's death was also reminding her powerfully of the 'loss' of her family of origin.

The work that followed involved complex themes around the current adoptive family relations (renegotiating the places for the living in a bereaved family could be viewed as an important restoration-oriented theme paralleling that of appropriately relocating the dead), and loss-oriented work in relation to her adoptive father around the anniversary of his death. However, the emphasis shifted progressively to Linda's loss of her biological family, with Linda finding this simultaneously both the most upsetting and most satisfying part of the therapeutic work. While the other themes could be adequately conceptualised in terms of the Dual Process Model, Walter's notion of bereavement as biography was a better guide for the issues around the loss through adoption.

At my suggestion Linda agreed to take the genogram home and consider with her husband what other information she might want to include. He had declined an invitation to the counselling sessions, but whereas Linda felt her adoptive family was 'dissolving', she identified her current marriage and children as very positive aspects of her life. Suggesting this genogram homework was a way of seeking to tap into her resources outside of therapy (Miller et al. 1997 p. 76), with a view to minimising the therapy's contribution. This emphasis on conversations with people outside therapy is

consistent with Walter's suggestion that bereavement can be productively viewed as a interpersonal process of re-storying within the natural social system.

Linda decided that she wanted to fill in some of the missing side of the genogram. With help from her husband she became very active in following up possible leads to help her trace her biological parents. Linda traced her biological mother to an address in Canada, but very poignantly discovered that she had died of bowel cancer about two months after her adoptive father had died. Understandably, Linda was extremely upset and saddened by this, but was also elated by her discovery that she had five (half-) brothers and sisters she had never known of before, who began to correspond with her and make phone contact.

Linda and her husband developed this genogram ('my family chart') on their home computer as Linda gathered information from her New World relatives, both about her own life as an infant and her adoption, and about her mother's life after the adoption. Linda learned that her mother gave her up for adoption after pressure from her own parents, and had often said through her adult life how much she regretted this. Linda was saddened by this news of her mother's regrets and loss, but also began to feel that she really did 'belong' in her biological family, that her mother had cared *about* her even though it had not been possible to care *for* her. As the genogram expanded, Linda began to feel that she had a position at the hub of three families (adoptive, family of origin, marriage and children) rather than teetering precariously on the edge of a void. Linda gave me a copy of this genogram to mark our final session.

This vignette very much simplifies the complex themes for Linda at a time when she had effectively lost three parents (adoptive father by death, adoptive mother's rejection, newly 'found' biological mother's very recent but previously unknown death) but had found a new family. The connection I wish to emphasise is the relation between a therapeutic emphasis on creating new stories about the self in relation to others, a focus on resources and social processes outside of therapy, and Walter's argument that bereavement work should enable the living to hold onto their dead if they want.

Linda's experience of bereavement from her mother seemed more a matter of restoring previously missing connections to the dead, rather than letting go. In constructing a biography of the dead through talking with other family members Linda was reconstructing new self-narratives - bereavement work as autobiography. It is possible that the difficulties in constructing a stable and satisfying identity in a postmodern era (Giddens 1991) may be particularly marked for some adopted people where contact with the biological family and its narrative/symbolic resources is lost.

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Section 3 Case Study

The functions of case studies: representation or persuasive construction?

Introduction

Case studies in counselling psychology may be written for a variety of purposes, such as demonstrating proficiency in therapy to an assessor (Davy 1999), as a joint therapeutic endeavour with a client (White and Epston 1990), or as an exercise in empathy and personal reflection (Macmillan 1992) which can itself be understood as a form of research or inquiry (Mair 1999). The form and content of a case study should be suited to its purpose.

My doctoral thesis concerns the importance of balancing relativistic and realist perspectives in counselling psychology. I have chosen to approach this by examining how the creative possibilities of textual/narrative metaphoricity in postmodern psychology can be combined with attention to context in a socially constructed world of significant economic, cultural and political inequalities.

In 1997 I wrote a case study about therapy with a client I will call 'Megan', for City University's post-MSc requirements[14], to demonstrate competence in narrative therapy, using deconstruction as therapy. That writing reflected my excitement with textual metaphoricity and postmodernism in therapy. However, a written case study is not a simple representation of clinical work, but is itself a construction (Spence 1989).

- Translating an extended series of verbal encounters into a short written form necessarily involves interpretation, selection and transformation of meaning (Ochs 1979, Kvale 1996, Chapter 9).

[14] This work is now subsumed within my doctoral portfolio following my change to DPsych registration.

- The presentation of a case is shaped by the writer's purposes and capabilities as much as the original clinical encounter (cf. Kaschak 1978, Mintz et al. 1973). When I first wrote about this case I needed to convince my assessors that I was competent to practise a specific therapeutic 'approach' as part of BPS Chartering requirements. This led towards a relatively conservative style of writing emphasising a single, coherent, and academic narrative of ethical professional practice, marginalising other possible accounts or interpretive registers. In van Maanen's ethnographic terminology (1988), my original study was written primarily in a realist genre, from a distanced position of interpretative omnipotence.

- Case presentation is intimately connected with the dominant discourses within which writers and readers are constituted. Deconstruction calls into question the covert norms which maintain the objectifying and pathologising gaze expressed in a professional's account of therapy (Burman 1999, p. 166). A deconstructive reading (Lather 1995) asks what is omitted altogether (is unspeakable), or what is only present through an implicit opposition in relation to something which is written about (is taken for granted or beyond question)?[15] This concern with the partiality (incompleteness) of the text can also be used to develop a critical reading (Lather, ibid) of therapeutic partiality (preference and promotion) concerning contextual issues of power and privilege.

Using a case study to show two different uses of deconstruction

I have chosen to present an extended case study of therapeutic work produced through a reflexive critical reading of the original shorter study I wrote about my work with Megan. The study as a whole has two distinct aims, to illustrate:

a) how deconstruction may be used as a form of therapy with a client following the narrative practices of White and Epston (1990), linked with the reconstruction of 'preferred' accounts; but also

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[15] For example, when anti-racist practice is discussed in relation to the disadvantage and oppression of black people, rather than white identity, privilege and collusion.

b) how deconstruction may be used by psychologists as a mode of reflective practice and continuing professional development

My second, reflexive commentary emphasises issues arising from a deconstructive, critical understanding of feminism (e.g. Amos and Parmar 1984, Burman 1998), as a contrast with the universalist and emancipatory reading of feminism I adopted when writing the original case commentary. My aim is to suggest how deconstruction can be used to forestall conservative closure of interpretation in relation to clinical practice.

The structure and style of this case study

The structure of this case study reflects this double function:

a) The **original commentary** of the 1997 case study which claimed to represent a deconstruction of the client's story is provided in plain typeface.

b) More recently, I have developed a **second reflexive commentary** by making the original case study the focus for further analysis through a critical reading. This second, reflexive commentary is provided in **'Arial'** typeface within boxes. This analysis derives from a 'hermeneutics of suspicion' (Habermas 1971, Ricoeur 1971), which demands repeated return to the interpreted text for further work, on the assumption that there is always meaning that escapes the reading, and always further meaning that can be constructed. 'Suspicion is directed towards the unconscious meaning which could occur in the conversation between the interpreter and the text. In the process of communication the interpreter should be aware of distortions that are caused by tradition or racism, for example' (Gouws 2000, p. 21).

This stylistic disjunction between the 'client' study and the 'meta-study' may seem clumsy, since it hinders the smooth flow of a written account. However, the use of devices like this is one way in which to foreground the textuality and constructed/constructive nature of such accounts, such as their specificity to a particular time, context and purpose, and in so doing facilitate a critical evaluation of their functions. Curt (1994) goes so far as to suggest that 'language which flows

naturally and easily must always, in a 'climate of problematisation', arouse suspicion. Its very ease and fluidity helps to beguile the reader into believing the text is merely mirroring the world 'as it really is', and obscures its ability to glamour that reality into being' (Curt 1994, p. 14).

Original commentary

Case study - 'Megan'

Introduction

This case study describes counselling work over a six week period between me and Megan, a 42 year old white Irish woman, at a GP practice in an inner-city area serving an ethnically diverse population where I was employed through the local clinical psychology service to provide brief counselling to individual adult clients referred by GPs.

The referral

One of the male doctors at the practice wrote referring Megan to me for 'depression', adding that Megan wanted help in managing her daughter's behaviour. The doctor wrote that the daughter might be anorexic.

Initial contact with the referrer

I felt it was unclear from the referral letter what sort of intervention might be needed and what the GP's expectations were, so I discussed the referral with the GP. He explained that he had only met the daughter, Cary (17 years old), on one occasion when she had refused a full medical examination, but he suspected as did Megan that she might be 'anorexic'.

The GP said that Megan seemed very depressed about her own inability to change this or other aspects of Cary's behaviour (described as 'unco-operative') and wanted someone (i.e. me) to help her 'come to terms with her helplessness'.

Requests for consultation or therapy often arise when one person in a triadic relationship is losing - it is possible that the doctor was feeling triangulated between the demands of the mother and the apparent 'resistance' of the daughter, and was seeking a way out by substituting a counsellor for their own place (the doctor did not seem interested in a suggestion that he and I could offer a joint consultation to Megan or Megan and Cary).

Second reflexive commentary

Within the first few lines of the study, I have already introduced four subjects (Megan, her daughter Cary, myself and the GP), yet the title names only one. The title does not simply summarise or 'represent' the case in any simple way, but also suggests certain readings of the text over others. In Gadamer's hermeneutical terms (1975), the title is part of a textual 'fore-structuring' shaping the horizon of potential meaning in the case study that in turn interacts with a reader's own fore-structured meaning horizon.[16]

My decision to name the study 'Megan' could be read as a demonstration of a client-focused attitude compatible with the 'decentred practice' of narrative therapy (White 1997) which positions the therapist's thoughts and concerns as peripheral to the client's best interests. However, there is also a sense in which this 'client-centred' / 'decentred therapist' stance is also a flight from context into text. The title implies that the focus for intervention, and hence responsibility for change, is located clearly within the identified patient's belief systems and her actions. Megan is constructed as the object for the critical gaze of therapist and reader, and as the necessary site for change. This is paradoxically both empowering and objectifying, in the same way that assertiveness training has aroused controversy in feminist circles (e.g. Crawford 1998). The woman is positioned as an object of pathology in need of intervention by others (here, specifically male others such as me and her GP) but is accorded the responsibility for change.

By contrast, more contextually oriented cybernetic therapies would note that Megan has been offered as the 'identified patient', but foreground the wider system that has produced and responded to the referral as the unit for analysis and intervention (e.g. Bor et al, 1996, Minuchin 1974). Some feminist analyses of family therapy (e.g. Bograd 1984, Goldner 1991, Hare-Mustin 1986, Jones 1990) have criticised the notion of circular causation for implicating women in provoking and maintaining their own abuse, but the contextual

[16] For a psychologist, Gadamer's concept of the 'horizon of [potential] meaning' is quite similar to Vygotsky's zone of proximal development (Vygotsky 1978), especially since Gadamer suggests that the horizon is 'realised' in some way through engagement with a reader's horizons; in Vygotskian terms, text and reader provide mutual scaffolding for each other.

emphasis of cybernetic family therapy also offers therapists a lens to look beyond the cognising individual towards social structures and processes - notably but not necessarily the family - providing analytics to connect the socio-political with the personal (Rowbotham et al. 1979).

Some alternative titles may help clarify this. For example, the study could be styled as 'Therapeutic responses to male violence against women', or 'Problematising masculine accountability in relation to therapy with an abused female client'. Drawing on the referring doctor's request to me, the study might be titled 'Help her come to terms with her helplessness', drawing attention to the traditional role of mental health services in pacifying women's distress and reproducing gendered power relations (see for example Kitzinger 1993, Ussher 1991, Masson 1993 and Kutchins and Kirk 1993). Such cybernetically informed titles might have seemed incompatible with presenting the case as a narrative study. However, these titles also make sense when read as narrative 'externalisations' of problems (e.g. Title: 'Megan and John protest against male violence'). Further, I have already made use of cybernetic theory in my reference to the referral as an attempt at substitution within a conflicted triangle, an idea linked with Haley's structural and strategic models of family therapy (Haley 1967, 1987). My wish to show theoretical consistency in the case study cannot adequately account for the focus on Megan in the title. The title of the case study reproduces a patriarchal dynamic that deflects critical attention from masculinity.

These titles do not necessarily offer 'better' readings of the case. Rather, my analysis draws attention to the necessary partiality of any reading or representation of clinical practice, in the double sense that any single account (a) offers an incomplete view of therapy, which is always open to elaboration or revision (see for example Scheflen's 1978 discussion of 'Susan's smile') and (b) is partial in the sense that it supports a particular set of purposes and values.

Original commentary

Setting up the initial session

I was unsure at this stage what therapeutic work might be possible, but accepted the referral for initial assessment. I wrote to Megan offering her an appointment at the practice for an 'initial discussion about counselling and the problems affecting her' (avoiding an assumption at this stage that Megan actually wanted counselling for herself as opposed to some other form of help (Street and Downey 1996, p. 14), and implying an approach to problems that views them as separate from or external to

persons in line with narrative approaches proposed by therapists such as White and Epston (e.g. 1990)).

Initial presentation

Megan arrived promptly, dressed in clean casual clothes, looking in fair physical health but above average weight for her height of about 5' 4". She made good eye contact, seemed well oriented, and was able to speak clearly with me in a conversation without apparent problems with concentration, memory etc. She initially described herself as 'feeling down quite a bit' and often tired, and seemed worried and rather thoughtful, but not clinically depressed in terms of the combinations of signs and symptoms specified in standard diagnostic manuals such as DSM-IV.

Second reflexive commentary

Some of my anxiety about assessment as a 'safe practitioner' is evident here. My references to DSM-IV, clinical depression and signs such as her orientation are not consistent with the narrative frame I claim to use, but are perhaps a defensive manoeuvre to forestall an imagined question, 'Did you assess her properly?', mixed with some unwitting allegiance to a medical or diagnostic model of distress.

Original commentary

The main problem that Megan initially presented concerned what she saw as her failure to help her daughter Cary, combined with a deep sense of responsibility for Cary's behaviour and perceived difficulties. Megan was particularly worried that Cary seemed very thin, and seemed to eat very little. The referring doctor had suggested to Megan that Cary might be anorexic, but neither of them had persuaded Cary to be medically examined or to co-operate with being weighed, monitoring food intake or even discussing the concern. Megan felt that she didn't know how to talk to her daughter, and didn't know what to do to protect her from harm. Megan described herself as failing as a mother with Cary, and feared that similar problems might arise in future with her two younger sons.

Second reflexive commentary

My analysis of the content of 'Megan's problems' and my conduct of the case was influenced by my engagement with feminist ideas concerning the problematic nature of 'mother-blaming' in many therapies (cf. Taylor 1996, Masson 1989). However, I tended not to include my own masculinity in the case study, and generally excluded masculinity from my understanding of the case process. It is notable that I did not include myself in the description of the 'initial presentation'. Again, this was not something justified by therapy theory, since second order cybernetic and constructionist therapies insist that the therapist is a part of the 'observing system' (von Foerster 1981) or co-constructed reality of therapy (MacNamee and Gergen 1992).

Writing from the standpoint of a feminist psychologist, Burman (1999) argues that there is some tendency for political and feminist concerns to become neutralised or deradicalised through recruitment into theoretic grand narratives or (disciplinary) 'bodies of knowledge', rather than remaining grounded in relation to actual bodies whose materiality signifies in terms of race, sex, class etc. (For instance, Burman points out that the BPS sanctioned a 'Psychology of Women' section, but not a 'Women's Psychology Section' (Burman 1999, p. 169).)

The details of the 'initial presentation' focus on the client's physical appearance and her verbal description of the problem. Other contextual dimensions potentially relevant to an understanding of 'helplessness'/empowerment are absent from the description, such as her class and ethnicity. It seems inadequate to claim that I omitted these at the time simply because the client did not suggest they were relevant to the problem, since neither did she tell me that her height, concentration or clothes were.

Deconstructive readings of the historical development of feminism (e.g. Amos and Parmar 1984, Carby 1987, McClintock 1995) suggest that it has sometimes provided collusive support to discourses of racism, colonialism, class and heterosexism (to name but a few) through an early emphasis on a romantic grand narrative of women's common oppression by patriarchy, with consequent common cause. This denial of potential difference and conflict between women, and disinterest in axes of ethnicity, class etc. has at times served to conceal and reproduce these forms of oppression and injustice. For example, my attempted commitment to focus on Megan's experience as a woman may have excluded a helpful focus on the treatment of working class Irish people by middle class doctors and therapists, or by the British police and judicial system. Ethically motivated attempts to focus on the significance of gender, sexuality, race, class etc. in therapy should take into account the ways in which these subject positions intersect and co-organise (Brah 1996).

I am not suggesting that psychologists can avoid partiality and selection in writing a case study, but that we must be vigilant about the perspectival biases this reflects and reproduces, systematically reviewing how this shapes our practice.

Original commentary

The therapeutic approach

I adopted a narrative and predominantly 'solution focused' approach to this work, aiming to work collaboratively with Megan to re-author and revise an initially very problem-saturated dominant narrative in order to help free 'the client from a particular kind of account or 'story', and opening the way to alternatives of greater possibility and promise' (Bor et al. 1996, p. 248). This approach was chosen for two main reasons:

- the 'problem-saturated' nature of the case from the referrer's viewpoint and the client's initial presentation in the first session
- narrative approaches stress working collaboratively with a client to form a coalition against an externalised problem, rather than against a problem internalised or located in the client or a third person. Externalising the problem seemed a useful way to try to avoid becoming frozen in a mother / daughter / therapist triangle (especially since it seemed unlikely that the daughter could be engaged at this point)

Second reflexive commentary

When I first wrote about this case, I tried to present my case conceptualisation and interventions as consistent with narrative therapy following social constructionist principles. However, in so doing I tended to downplay other theoretical and personal experiences which shaped my response. I was at pains to present myself to my assessors as influenced by a single dominant theoretical narrative, and my anxiety about assessment made me hide or ignore other influences.

Looking back on the encounter as a whole (rather than my client), it seems both inevitable and obvious that my professional practice and theorisation in relation to the case was something messier and socially constructed, arising epigenetically (Bertrando 2000) through

the interaction between my prior experiences and engagement with different discursive structures.

For example, my initial case conceptualisations actually owed something to Milan systemic and structural models of family therapy which I had tried to use in my previous career as an educational psychologist, while my style of engagement with Megan probably owed much to my person-centred counsellor training (which I seldom wrote about during my counselling psychologist training, perhaps thinking that this was somehow a 'lower status' form of therapy).

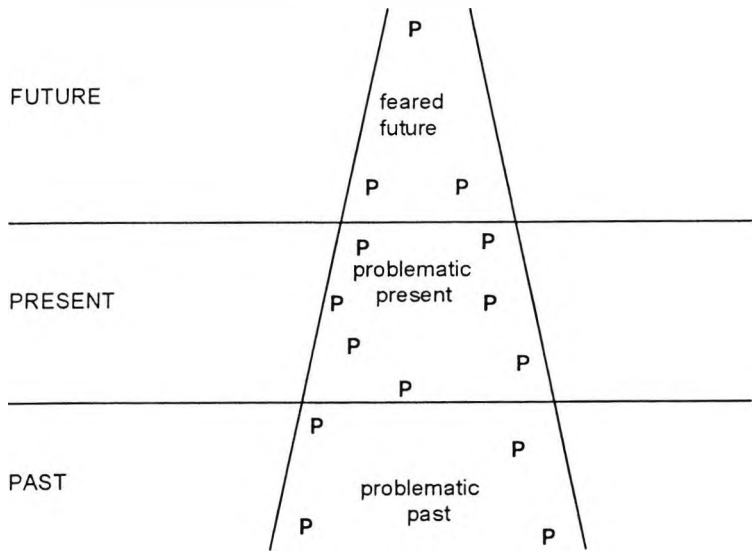
Original commentary

(A) Identifying dominant narratives...

White and Epston (1990) argue that 'in striving to make sense of life, persons face the task of arranging their experience of events across time in such a way as to arrive at a coherent account of themselves and the work around them... The success of this storying of experience provides persons with a sense of continuity and meaning in their lives...' (White and Epston 1990, p. 10).

For many clients this dominant story may seem very problem-saturated, inadequately representing their lived experience and implying a feared future, failing to offer pathways to more satisfying 'story endings' (see Figure 1).

Figure 1 - Diagrammatic representation of a dominant narrative brought to therapy with a problem (P) filled past and present implying a feared future, with a relatively narrow range of future paths available for consideration and little emphasis on resources and skills used before and available now



Second reflexive commentary

Although I intended to portray my therapy with Megan as grounded in a discursive and postmodern form of narrative therapy, on reflection I realise how this diagrammatic representation focuses attention on the identified patient's individual story-making and story-changing processes, rather than the social construction of experience and the co-construction of lived reality. Narrative therapy's apparent return to the individual's sense-making processes can be understood as a rapprochement between systemic therapies and humanism (Bertrando 2000), replacing cybernetic epistemology with the metaphor of narrativity and a renewed interest in clients' authorial status and autonomy. However, the narrative emphasis on textuality and individuals' capacity to 're-author' their lives potentially risks losing the contextual and interactive sophistication of the systemic therapies it developed from (Bertrando 2000). With minor modification, the diagram above could equally represent the core message of cognitive therapy for clients that 'You don't have to see it that way. There could be another way of seeing things' (Butler 2000, p. 25), or a weak form of Kellyian constructive alternativism (Kelly 1955, p. 15). It seems important to keep asking whose narratives should be in question, and how empowerment and protection can be reconciled with just responsibility.

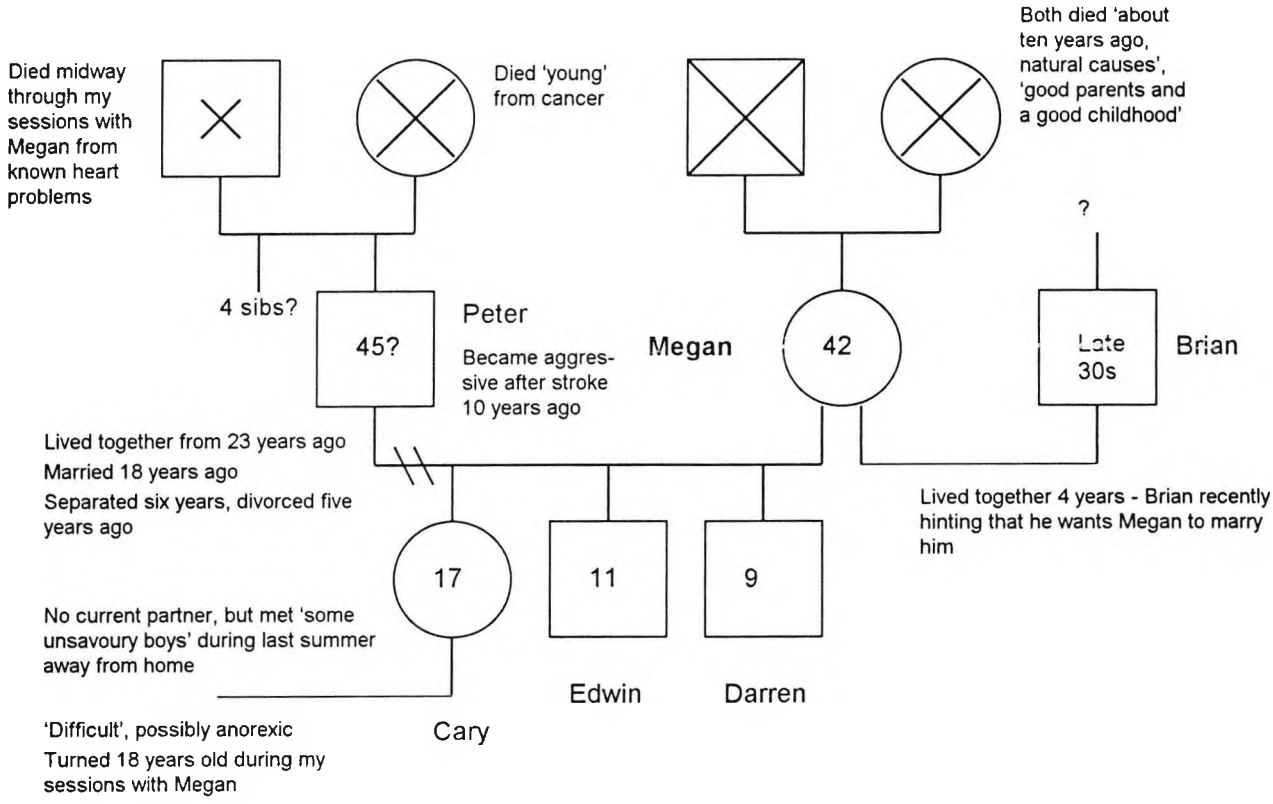
A measure of distrust is also required in our attitude towards our own answers to these questions and to clients' answers. After all, if one believes that subjectivity is constructed, a client's formulation of, and attitudes towards, their 'own' goals are as socially constructed as the therapist's. On what basis then do the client's goals constitute a privileged and necessarily benign means for evaluating and guiding therapy? (If Megan's daughter Cary were to tell a solution-focused therapist that her goal is to become as thin as possible, should the therapist simply accept this? If not, on what authority can the therapist presume to offer a valid construction of the goal, given that the therapist's subjectivity is also discursively produced?)

Original commentary

Megan lived with her partner of four years, Brian, and her three children aged 17, 11, and 9 by her marriage to Peter. Megan felt she had experienced increasing difficulty in 'dealing' with Cary's behaviour (e.g. arguing and 'answering back', not eating, staying out late) since her separation from Peter six years ago, with a sharp turn for the worse (including 'worrying' changes in her appearance and diet) when Cary had spent a summer away from Megan and Brian working at a fruit farm, after which she had initially returned to stay with her father, who still lived nearby.

Megan said Cary seemed even more unhappy and uncommunicative since returning to Megan's about three months previously, and worried that Cary might leave home for another summer job soon, when she feared that Cary's health might suffer if she continued not to eat.

Figure 2 - Summary genogram (from information over all sessions)



It also became apparent that Megan was worried about Cary going to stay with Peter again. This did indeed happen midway through our sessions when Peter's father died. Cary went to stay with Peter to organise her grandfather's funeral and started cooking for Peter. By this time, Cary had turned 18 years old, but it was apparent that Megan found it hard to think of Cary as an adult making her own decisions.

A process of shame and failing words...

Megan explained that she felt that her own upbringing and early adult life had been good until about ten years ago when her husband Peter had suffered a small stroke. She described Peter as becoming increasingly aggressive to her after this, both verbally and physically, drinking heavily, and becoming extremely sexually demanding.

Megan had seemed articulate describing her concerns about Cary's eating habits, and described several strategies she had tried to address these, but she became very quiet and halting when she began to talk about Peter's violence towards her. She dropped her eyes, with tears forming and her cheeks reddening. It seemed difficult to stay on this theme, and a number of times our conversation returned to the daughter's behaviours and Megan's concerns about these.

I commented that I was aware that she was trying to tell me about some very painful experiences which had affected her very directly but was perhaps finding it very hard to find the words, as if the experience was almost unspeakable. At this, Megan looked at me very directly, still crying, and told me that Peter raped her repeatedly over a period of more than two years, and told me how very ashamed she was about this, particularly that 'If I told you that he raped me both ways, would you know what I mean? - both ways, I can't say more than that about it, I feel so ashamed, so dirty'. I said 'So ashamed, very difficult to speak about it at all... although you have managed it here just now. I think perhaps I do know what you mean by 'both ways' - do you mean that he buggered you?' (I was very unsure here whether to use another term here, as I felt that Megan used the phrase she did as a way of maintaining some distance from the experience, but also felt it might be important to check and confirm that she had been able to communicate effectively to me what happened, and also to test out that it might be possible to speak the unspeakable at least in this relatively 'private' space.)

Megan nodded vigorously, and told me more details about the abuse, this time with more volume and eye contact although still crying and stumbling for words. She explained that she had tried to keep silent throughout these experiences for the children's sake, but was also deeply ashamed and upset that Cary had heard her cry out against Peter 'taking me both ways' at least once.

A little told story...

She also explained that after one particularly brutal assault Cary had seen her in the shower with bad bruising across her thigh, and had asked 'did Daddy do that', to which Megan answered 'yes'. Megan was worried about the injury and had gone to

her male Asian GP (at a different practice), who had been dismissive and irritated when she tried to explain how it had happened. Megan told me that this was the only time she had thought of trying to tell someone about the sexual violence against her, although she had told Brian that Peter had been violent. I was the first person she had told about being repeatedly raped and buggered.

Second reflexive commentary

Looking back on my original commentary with a critical eye, I am saddened to see my own unwitting racism at work in the text. If the ethnicity of that GP was relevant, why had I not previously discussed my own and that of other subjects in this narrative, besides Megan? If instead I believed that professionals' ethnicity was not a relevant therapeutic dimension, then why did I describe this GP as 'Asian'? Simple naiveté cannot account for this.

Original commentary

Megan explained that she eventually left when Peter kicked the youngest child in the head one evening, which had led to a difficult time living in hostels on low benefits, with many moves until they settled with Brian who she described 'a good man, like Peter before the stroke, very gentle'.

A summary of a dominant narrative...

Megan saw herself as a bad mother who had not managed to protect her children from Peter's violence and aggression, and might be failing again in protecting her children from both Peter and other possible dangers in the world. She saw this failure primarily in terms of her failure to find ways of communicating with Cary, and her failure to 'stand up to' Peter. Megan felt 'dirty' and ashamed as a result of her experiences of physical and sexual abuse by Peter, and saw herself as powerless and unable to take action or speak out against male violence.

Megan recognised these themes when I offered them towards the end of the session as my understanding of our conversation to that point, and seemed relieved that this much had been heard and told.

(B) Inviting an alliance against a problem...

Narrative therapists actively seek to engage with clients in an alliance, but aiming to ally against problems seen as external to the client and significant others rather than owned by or located within them. The therapist's intention is to help the client contextualise and locate the problem in relation to meaning systems or discourses within their social context - this could include family belief systems, but also broadens the scope for exploration and change in therapy to the client's relationship with social and political forces/discourses beyond the family (White 1989, Bor et al. 1996, p. 252). We agreed that we would work together for five further weekly sessions to (a) consider the effects of communication problems on her, and her influence on the communication problems, and (b) look more closely at the relationship between her experience and the notion that she was a bad mother who failed her children.

Second reflexive commentary

While I was working with Megan I was also in training as a counselling psychologist, and acutely aware that I needed to get a certain number of placement hours. In the original case study, I presented as unremarkable my choice to offer five further sessions. In fact, the counselling service I worked for did not allow longer contracts, and I do not mention the possibility that I could instead have referred Megan to a secondary mental health service with less restrictions on the contracts that could be offered (and which could have offered a choice of male or female therapist). I think that I endeavoured to provide an ethical and appropriate service to Megan, but by omitting these contextual factors in the written account I minimised the study's transparency about my institutional power as a gatekeeper to other services.

There is an ethical requirement to link the textuality of this case study with the context of the work. I am writing in this case study as a white middle-class male psychologist (Welsh, with an English accent) about therapy with a working-class Irish female client, where the concerns discussed in the sessions relate significantly to the abuse of women by men. The way in which I conducted the therapy and then wrote about this work is not separate from this. In making my own beliefs and writing part of the system which this study examines, I am attempting to develop a reflexive and accountable practice (cf. Lax 1992, Law 1999).

In this sense, both therapy and the original case study reproduced a patriarchal structure in which women are objectified through the pathologising gaze of men, while male actions and beliefs remain distant or unquestioned as the covert norm. I conducted the therapy with a concern to help Megan 're-author' stories about herself as a resourceful and competent

mother, but in so doing retained 'motherhood' as a central discourse rather than fatherhood, male sexuality and violence, and thereby also replicated male bystanding (Clarkson 1996).

Original commentary

(C) Reclamation of subjugated narrative and construction of alternative narratives

'Life experience is richer than discourse. Narrative structures organise and give meaning to experience, but there are always feelings and lived experience not fully encompassed by the dominant story' (Bruner 1986, p. 143). The narrative therapist aims to help a client construct a narrative implying more resourceful future possibilities by:

- Helping the client identify and reclaim resourceful and rewarding aspects of experience which have been disregarded or forgotten as inconsistent with the dominant narrative. This can be understood as a search for times when the 'problem didn't happen', for 'exceptions' (e.g. de Shazer et al. 1986) or 'unique occurrences' (White and Epston 1990). Similarly, problematic issues already discussed can often be reframed as evidence of the survival capacity of the client (Wilson 1997, p. 62). A few examples from the work with Megan include:
    - she had survived two years of very severe abuse, remaining able to provide for three children, seek new part-time work and find a new partner
    - she acted effectively to protect the children and herself when she left Peter and sought divorce
    - she had given up her enjoyable work as a school cook to look after her children while they were in temporary accommodation, after considering leaving them with a childminder instead
    - although Megan found Cary 'difficult', the two younger children seemed to be 'turning out well', which she agreed owed a lot to her
    - Megan had been able to 'speak the unspeakable' in telling me about her sexual violation by Peter

- between sessions four and five, Cary told Megan that she felt maybe she had lost too much weight, allowed Megan to watch her weigh herself, and agreed that Megan should make her an appointment with the doctor

- Seeking to bring into awareness stories about other possibilities which were not experienced, or generate alternative visions of the future. Narrative therapists emphasise the exploration of negative explanation and restraints, asking not so much how the current pattern developed and is sustained, but wondering instead why other patterns haven't developed instead, or why clients envisage one form of likely future rather than other possibilities (Bateson 1972, p. 399).

Why didn't Megan leave Peter sooner? Megan felt that this would have been financially very difficult; instead, she had started putting money aside 'just in case'. Also, she felt that a transient life in hostels would have been very hard with a 1 or 2 year old; when she did leave, Cary had started at her new secondary school, Edwin at a primary school, and a nursery place was due shortly for Darren. Megan began to feel that (a) her timing reflected some very caring motherly planning, (b) her dilemma was one shared by many women in a society where financial circumstances and childcare arrangements help keep women entangled in abusive relationships, and where women trying to disclose abuse within a marriage may be seen as 'disloyal' or at fault themselves, as when Megan had tried disclosing to her previous doctor, (c) she was frightened about Peter's reaction if she tried to leave, which she decided was not so much due to her being a bad mother as a well founded fear of abusive treatment.

Asking Megan why she thought Cary didn't allow herself to be closely 'protected' by staying in each evening and having her diet monitored led Megan to think about Cary's age and place in the family and increasingly decide that it might be appropriate for rules to be different for an 18 year old on the verge of leaving home, compared to the younger children. Previously there had been significant conflict between her and Cary as Megan had demanded that what was 'a rule for one should be a rule for all'.

- Helping the client to voice or 'perform' existing alternative narratives which may be already be in awareness but hard to 'perform' and lacking power in relation to the dominant story. ('Some experiences are inchoate, in that we simply do not understand what we are experiencing, either because the experiences are not storyable, or because we lack the performance and narrative resources, or because vocabulary is lacking' (Bruner 1986, pp. 6-7)).

In our last session Megan told me that she had recently been to see the referring doctor about a minor problem, and while he was examining her she had told him that she was violently raped by her ex-husband. The GP was rather taken aback and made little response. This did not concern Megan, who felt elated that she had been able to disclose this information to the GP, in contrast to her years of silence after a previous GP had angrily dismissed her attempts to speak of Peter's violent abuse. To her, this represented another step in overcoming a powerful story of shame and silence taken independently, after our work together 'rehearsing' lines for a new narrative.

Megan told me that she had recently told Cary she had been coming for counselling, which we agreed was one step in working out how to talk with Cary about the family's experience and perhaps help Cary avoid some pitfalls in her own adult life. This reminded me of the feminist psychologist Jean Baker Miller arguing in 1976 that 'Women start... from a position in which they have been dominated. To move out of that position requires a power base from which to make even the first step, that is to resist attempts to control and limit them. And women need to move on from this first step to more power - the power to make full development possible.' Reclaiming or reconstructing a self-narrative as an abused but resilient woman with the power to speak in therapy had been a first step, but Megan was also taking second and third steps outside the therapy sessions.

The use of supervision

In addition to her concerns about her daughter Cary (legally an adult during the latter half of the therapy) Megan worried about her two younger children's safety with their father Peter. He came round to meet his two sons each week, sitting with them in a local pub for the afternoon. Megan thought that Peter was very moody and so might

upset the children, and felt that Peter should not be taking them to a pub. She said she was too frightened to ask him not to, and felt that no-one else would help enforce a ban on contact.

There was no direct evidence from Megan's account that the children were currently being abused or maltreated by Peter, but I felt concerned given Megan's accounts of her experience of Peter. Discussing these feelings with my supervisor helped me manage my anxiety about the case and encouraged me to take a more active approach with Megan in considering possible problematic future scenarios.

In order to get to a point where Megan and I could work together on possible alternative futures and solutions which could help protect the children's safety, it seemed necessary to help Megan articulate a more explicit vision of what a 'feared future' implied by the problematic past and present might be. This was done through future-oriented questions such as 'How long do you think this is likely to go on for?', 'What are you worried might happen as a result of these mood swings?' etc. Before the fifth session, Megan confronted Peter in the street in front of neighbours and told him not to come round again or else she would hit him and call the police. Peter left without an argument. Megan described her confrontation with Peter as a voicing of great anger which she had long felt but which had been largely 'buried' under fear and shame.

Second reflexive commentary

I remember feeling quite pleased about the way I handled this, and I also recall a sense of satisfaction that this had helped to 'push Peter out of the picture'. Perhaps I resented his continuing presence in the warmer, more resourceful textual world (a 'nicer' story) that Megan and I were co-constructing in language. And yet, bearing in mind the other possible titles I could have chosen for this case study that would demand a focus on male accountability and attention to the social context of male abuse of women, I wonder now whether it is significant that I did not write more about Peter, or talk more with Megan about Peter and his future rather than Megan and hers. As I suggested earlier, my understanding of the dominant narrative in her story concerned bad vs. good mothering, but this was an act of interpretation on my part. I could equally have 'reflected' back to Megan that the problem affecting her life seemed to be lack of male accountability and control.

What are the possible consequences of my inattention to Peter and preference for talking about resourceful motherhood? Peter remained at large in the community as a violent rapist whose crimes had never been reported to the police. From another perspective still, Peter remained a patient who might be suffering from untreated neurological problems and/or poorly managed mental illness. An emphasis on male responsibility and actions in the therapy with Megan might have led towards measures to address these issues, or would at least have acknowledged the injustice of the situation.

As a responsible psychologist, it is important to consider ways in which the textual conduct of therapy with a client may have consequences in wider contexts and communities (such as Peter's potential future partners or children). This implies a broader focus than understanding how contextual considerations shape a client's life. Necessarily, any therapy can still only address a limited number and range of issues, but a responsible psychologist should endeavour to make such selections knowingly and accountably.

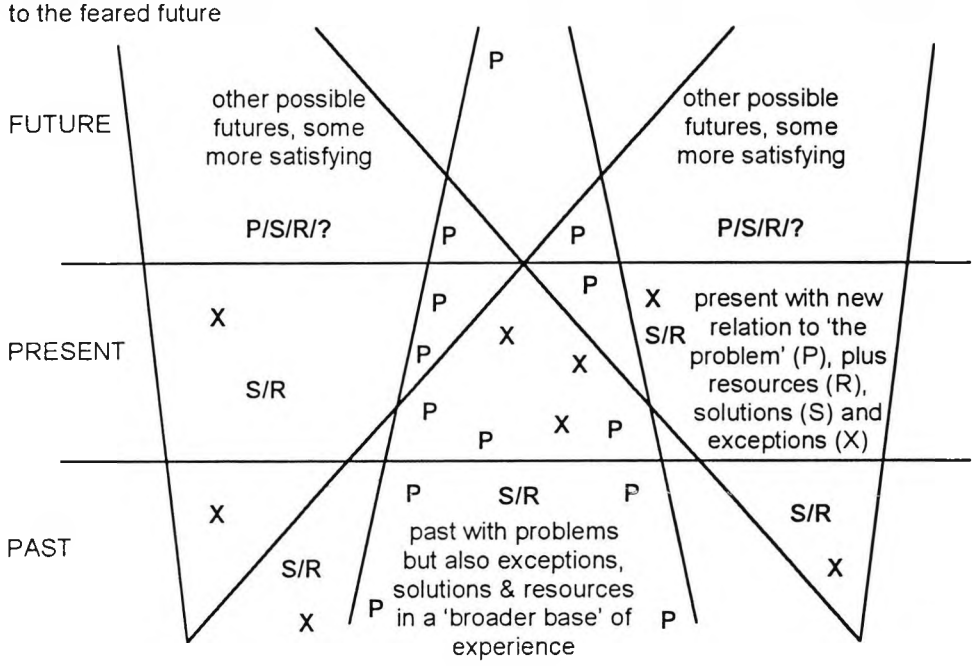
Original commentary

A revised narrative towards the end of therapy

Megan felt that she had been badly treated in her marriage but had been resilient and survived still able to work, love and care for her children. She felt angry and damaged by the abuse, but no longer ashamed - she felt the shame 'belonged' to Peter. Megan was no longer frightened of Peter, but thought it would be important to help her daughter understand more about the dangers of 'some men out there'. Megan remained very concerned about Cary, but felt that she needed to concentrate her efforts on caring for the two younger ones with Cary taking more responsibility for herself. She felt very pleased at having acted to keep Peter away from the younger children, and felt she could do this again if necessary.

Megan's vision of the future for herself was unclear but included some glimpses of possible growthful changes. She started thinking about returning to work, and at the very end of therapy Megan told me that Brian was dropping hints about marrying her. She said she 'wasn't going to get trapped again in all that, no thanks!', but also looked and sounded much happier and more relaxed than at any other point in the therapy - it was perhaps possible for Megan to begin to view possible futures which did not revolve so strongly around a 'caring mother' identity.

Figure 3 - New narratives produced and practised - a broader range or different base o past and present experience implies a greater variety of futures - some more clearly envisaged than others, but developed with a greater awareness of resources and solutions and with a different personal relationship to the original 'problem' leading to the feared future



Second reflexive commentary

Figures 1 and 3 both suggest a kind of textual mapping process, in which a self-narrative suggests a route forward, and therapy aims to mark alternative routes. However, the map has no contours, representing a world of level playing fields. Attention to material and socio-cultural issues should remind the psychologist that there are plenty of uphill slopes and impassable swamps on the territory. Historically, British justice is not easy terrain for Irish people given the colonial tensions on the island of Ireland and infamous miscarriages of justice such as the imprisonment of the Guildford Four. Failure to recognise this interdependence between textual route maps and the contextual territory implies a simple deficit model, that clients just lack the imaginative capacity to devise new stories and routes.

It follows that such route maps must be developed in combination with a careful mapping of the contextual territory for any given client. The terrain for a middle-class male is different than that open to a working-class female. This is not a radical relativist position; rather, it is a recognition that our materiality (the presence and history of our embodied selves) signifies in the social world. To say that sexism, or racism, or ageism, is socially constructed is a long way from denying that these have real effects. There is a complex dialectic (Levins and Lewontin 1985) between our construction of the world and the potentialities for construction which it offers us (Willig 1999), theorised by Bhaskar (1978) as 'critical realism'.

Original commentary

Learning about myself and about psychological counselling

Post-modernism's specification of possible 'constructions of meaning' in contrast to modernist 'truths' has led some therapists (e.g. Flaskas 1997) to express concern that clients' lived experience and abusive experiences may be invalidated in some sense if they are seen as 'just another story' which can simply be re-edited to produce a more comfortable view. Flaskas cites Harari on the match between narrative metaphors and Holocaust survivors' experience:

> The narrative approaches... have provided bridges between subjective experiences and the social and historical contexts in which subjectivity is constructed. However, the Holocaust survivor is not just telling a story. He/she is also a witness, someone who is giving testimony. For the survivor, there is not the plurality of readings or multiple perspectives of equivalent validity from which the story may be told. The survivors fear that if the *empirical links between life experience and its narration* are modified in any way their story will be lost (Harari 1995, p. 13, in Flaskas 1997, p. 14 with her added emphasis).

I have felt uneasy in the past about using narrative therapy for such reasons, worrying that helping clients re-author their lives could seem tantamount to dismissing their experiences as 'just stories'. However, this case has helped me to appreciate that narrative therapies can also be about helping validate and witness narratives of oppression and survival which might otherwise be unperformed and unavailable for the client and others as a resource for future living.

Instead of assuming narrative therapy is only about co-writing new stories with clients, I now understand narrative therapy as about working with the client to develop narrative resources, such as finding and rehearsing an effective voice to tell a previously subjugated narrative.

The use of supervision regarding the safety of the younger children has also helped me consider a limitation of solution-focused therapy. Sometimes, it may be necessary to help a client elaborate their vision of a feared future (this is perhaps similar to the technique of 'escalation' in some strategic therapies in order to create sufficient motivation to seek new understandings and behaviours).

Second reflexive commentary

I have not written this case study as a 'mea culpa' or confessional story (van Maanen 1988) which I can now narrate from a morally superior position. My reflexive commentary is not a 'better' reading of the case in any simple objective sense. Rather, I am aiming to demonstrate the partiality of possible readings and some implications of this, through an impressionistic account focusing on the process of knowing, as well as the knower and the known (van Maanen 1988). I approach this task with a perspectival position that has changed since 1997 as I have read and reflected more on work identified with feminist psychology. This case study is therefore performative rather than simply instructional, since I am hoping to show how deconstructive processes applied to one's own professional studies and writing can be used to develop different sensitivities and hence possibilities for responsible action within a critical realist framework (Bhaskar 1978, Willig 1999).

I began my commentary on this case study by problematising its title. There is a parallel with the lengthy debate in social psychology and psychotherapy concerning the functions of 'labelling' and diagnosis, but there are also connections with issues of voice and speaking position (Richardson 1990, pp. 26-27, Herz 1997, Burman 1999). Am I writing about Megan, with her, on her behalf, about myself, or what? What right or responsibility do I have to foreground her experience in this case study? Megan gave me permission to write about her, providing I took steps to obscure her identity in certain respects she specified. She did this on the basis that reflecting on her story might help me, and perhaps other therapists, understand better how to work constructively and ethically with women who have experienced violence from men. In this sense, I am grateful to her for permission to use our work together as an impetus to reflection, and arguably had a duty to my client to reflect further on our work together. However, I must also accept responsibility for the account I develop. This is my story or interpretation from my journey with her, not an attempt to represent her perspective or experience in any direct sense.

Afterword

Many of the 'helping' professions encourage the use of reflective journals and case study writing as an aid to the development of professional skills and identity (e.g. Allen and Bowers 1989, Holly 1989, Palmer et al. 1994), and as a way to make sense of complex clinical experiences (e.g. Noble 1999).

Game (1991) suggests that writing can be seen as a transformational process which creates possibilities to rewrite cultural texts and reformulate issues of social change, but emphasises that reading is itself a form of writing practice. She suggests that texts

should be evaluated for their capacity to provoke 'disturbing pleasure', in which the reader comes to re-evaluate their own purposes (Rorty 1992, p. 106) and desire for knowledge, opening up new questions. Using Barthes' terminology (1981) I have tried to present my case study as a 'writerly' text (i.e. one which invites readers to write themselves into it and extend its meaning), rather than as a 'readerly' text (in which the reader's task is simply to 'receive' what the writer intended).

I suggest that counselling psychologists need to practise and develop their reading skills and sensitivities as much as their writing, learning to apply these systematically to their own texts and to themselves as a form of critical reflexive practice. Whenever we write, we are writing about and through our beliefs and biases. Each text we create is an act with functions and consequences (cf. Austin 1962, Wittgenstein 1958), not simply a neutral representation of an existing state in the world. Just as our writing has effects for clients (e.g. White and Epston 1990, Ryle 1991), so too will our texts act on ourselves to sediment or perturb our own identities.

Some specific recommendations arising from this line of thought in relation to professional development include:

- Training courses should support counselling psychologists to experiment with a broader range of writing formats and genres, introducing ideas from cognate disciplines such as literary theory, poetics (Mair 1989) and creative writing.

  In particular, it may be helpful to encourage forms of writing which counterpose different voices or interpretations of the 'same' situation (e.g. analysing different transcription styles for the 'same' interview segment (Riessman 1993, Mishler 1991, Gee 1985)), and which acknowledge the writer as a subject within the system of inquiry who will have mixed feelings and multiple motivations for their (in)actions (Macmillan 1992).

- Training courses should teach critical reading skills (Lather 1995), and assess psychologists on their interpretative capacities as much as their descriptive skills.

- Trainees could be asked to re-read previous case studies to analyse their own developing process and emergent professional sensitivities in relation to their new

understanding of the text. This would promote an ongoing hermeneutic approach to training and self-work, rather than the simple accumulation of core competencies.

- There may be a need for continuing professional development for experienced psychologists in relation to these issues. In particular, many trainers will have developed through professional trainings that emphasise the coherence, clarity and 'central meaning' of accounts (Potter and Wetherell 1987, p. 168), rather than diversity, ambiguity and creativity.

- All psychologists need support to examine the political complexities inherent in ethically motivated practice. In particular, there is a need to avoid overly reductionist emphases on isolated identity categories, while still retaining focus on the constitutive effects of social structures, injustices and inequalities.

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