THE EXPERT THERAPIST

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INTRODUCTION

This article explores how cognitive therapists frequently use discourse to mobilise two distinct subject positions; themselves as 'experts' and their clients as 'laypeople'. This positioning is achieved by therapists selectively drawing on various repertoires and by using a range of discursive strategies. Essentially, these repertoires and strategies interweave to provide a powerful cumulative warranting effect that establishes the positions of 'expert' and 'layperson'. Our focus is on one particular repertoire and three discursive strategies that therapists use, in order to emphasise how these positions are attained. Throughout we highlight some of the positive and negative therapeutic implications that such positioning entails.

POSITIONING THEORY: A BRIEF EXPLANATION

According to Davies and Harré's (1990) 'positioning theory', a subject position is created when people in interaction use language to negotiate positions for themselves. As Burr (1995) explains:

> *Discourses provide us with conceptual repertoires with which we can represent ourselves and others. They provide us with ways of describing a person… Each discourse provides a limited number of 'slots' for people… These are the subject positions that are available for people to occupy when they draw on this discourse. Every discourse has within it a number of subject positions…* (p. 141).

The subject positions that are taken up by people are achieved by individuals negotiating different and shifting identities and accounts which reflect the contingencies of their accounting situation (Wetherell, 1999). Many different kinds of subject positions are actualised from moment-to-moment, and these may be offered, accepted, claimed or resisted by the individuals (Davies & Harré, 1999). Subject positions emerge and are identified by focusing on the discourses manifestation between individuals and by noticing the effects that these discourses have (Langenhove & Harré, 1999). Thus, the use of discourse creates subject positions, and the positions available are contingent on the individuals understanding of the discourse.

Davies and Harré (1990) also acknowledge that people are both products of discourse, and producers of discourse. They are products in the social constructionist sense in that their identities "come to be produced by socially and culturally available discourse" (p. 140). They are producers in the individualistic sense in that within the cultural and social discourses available, individuals in interactions manipulate discourse to position themselves as they "manoeuvre in the prevailing discourses" (p. 141). Thus, the use of discourse in social interaction has the function of creating different subject positions, and positioning refers to this process of negotiated identity or account construction (Langenhove & Harré, 1999).

In addition, the positions available within discourses bring with them a 'structure of rights' (Davies & Harré, 1990). This entails that each subject position not only provides a sense of "who we are" (Burr, 1995, p. 145), but also the possibilities for and limitations on action within a particular discourse (Davies & Harré, 1990). Thus, different constructions of an interaction can

offer different subject positions, which entail different rights, obligations and possibilities for action. Hence, subject positions have implications for power relations as they constrain and shape what an individual can do. In other words, each individual is exposed to an interaction of different discourses, each with its own possible subject positions, structure of rights, obligations and possibilities for action, and each carrying different power implications.

APPLYING POSITIONING THEORY: FROM THEORY TO PRACTICE

With regard to positioning theory, we were interested in the ways cognitive therapists utilised different discursive strategies and repertoires to position themselves and their clients, and the various effects the positioning had for the therapeutic process. In order to determine the various positioning that was happening in the interactions, our focus was on the way therapists used particular strategies to present and describe themselves and others, as well as the 'structure of rights' entailed by the positions.

For the purposes of this article, we have chosen to focus on the two main and most frequently adopted positions discerned in the therapeutic process; the therapist as the 'expert' and the client as the 'layperson'. We have also chosen to outline only three of the most common discursive strategies and a repertoire that was used to enable and support this particular positioning. These three discursive strategies included the way therapists imparted knowledge, made extreme cases, and concealed information from their clients. The supportive repertoire was a moral repertoire which alluded to the therapists as moral experts. These strategies and this repertoire were tied to practices which supported and maintained positions of power and dominance for the therapists, to which they then utilised for therapeutic effect.

POSITIONING OVERVIEW

When therapists were conversing with other therapists or clients, they frequently adopted and became enmeshed in the subject position of an 'expert'. From this position, the therapists warranted all the rights, responsibilities, standards, reputations, and entailments usually given to or assumed by an expert. In more practical terms, adopting this position provided therapeutic credibility, validated their accounts, and established various 'medical powers' relevant to the therapeutic change process.

From this 'expert' position, therapists frequently positioned their clients, and their clients adopted (although we do not explicitly cover this aspect), the opposite subject position of 'layperson'. In this position, the clients were passive, sub-optimal and deficient of knowledge and skill, entailing a somewhat diminished status. In more practical terms, the client was afforded lesser rights to make decisions, have input into and control over the therapy process, and afforded less ability to use and converse in relevant psychological terminology, and the positioning that entailed from this usage.

METHODOLOGY

The multi-media approach of this research involved obtaining three distinctly different types of talk and text from within the cognitive therapy domain. These consisted of cognitive therapy instructional books, cognitive therapy demonstration videos, and interviews with practicing cognitive

therapists (Ethical approval was obtained from the Massey University Human Ethics Committee).

Theoretically and practically this translated into a better understanding of how discourse was being used and constructed within and across the cognitive therapy domain. In other words, by strategically employing a multi-media approach from the outset we were able to gain a much wider exploratory scope of the discursive resources and practices utilised.

UTILISED POSITIONING STRATEGIES

Imparting Knowledge.

The first discursive strategy that will be discussed involved therapists highlighting their privileged knowledge through the use of an educative role, in order to warrant an expert status. Here therapists constructed themselves as "gatekeepers to a restricted and exclusive realm of knowledge" (Langenhove & Harré, 1999, p. 27) which they then imparted to their clients in an educative fashion. A selection of the ways therapists assumed this educative role can be discerned in the following extracts (note: bold text highlights our added emphasis):

> *Therapist: …this belief, which* ***I think you might realise, is not a correct belief****, …you probably realised that…*

> *Therapist: …and what I want to ask you is, to look at these two lists and see what you see as the connection between these two lists,* ***you've already kind of said it, but I would just like you to say it again****…*

> *Therapist: Okay, and um, when,* ***have you being paying attention*** *focusing on your sensations while you've been writing?*

> *Therapist: Okay,* ***why=don't=you write that down****, that when I'm paying attention to other things and when I'm not focusing on sensations, they can go down.*

This educative role was also reinforced with a number of distinctive phrasings that strengthened both their knowledge and status:

> *Therapist:* ***So the bottom line was****, that you believed that…*

> *Therapist: Ok,* ***SO, let=me=get=this=straight****. So you had a series of sensations, and these thoughts, and* ***let me just point out now*** *which sensations went with which thoughts,…*

> *Therapist: Ok,* ***SO, here we have now then*** *a list of sensations which you experienced,…*

This educative role served to persuade the client, strengthen their faith in the therapist and therapy process, and to give credibility to the therapeutic framework. This put the therapists in a largely paternalistic and authoritative

position, assuming a rather beneficent and non-maleficent role, which established their expert status.

However, this educative role did not always entail beneficial consequences. For example, there were no instances where the clients asked for clarification or questioned the therapists. In contrast, there were countless instances where the therapists asked for clarification or questioned their clients, for example:

> *Therapist: You feel much better now, okay, now I want to ask you, **how do you explain that**? A few minutes ago you were having these very intense uncomfortable sensations now you feel better!*
> *Client: I **guess** when I am writing I now feeling less anxious.*

Here the direct questioning resulted in the client becoming less sure of herself, in contrast to previous dialogue. Nonetheless, despite the occasional detrimental effect, the educative role aided in warranting the therapists' expert status.

Going to Extremes.

A second discursive strategy involved the regular use of 'extreme case formulations' (Pomerantz, 1986). Extreme case formulations involve taking a position being advocated to its extreme in order to help make that position more persuasive (Coyle, 1995; Gergen, 1989). In the therapists case, this included the use of terms such as 'always', 'never', 'nobody', 'really', 'extremely' and 'everyone'. Examples of the use of these terms can be seen in the following extracts:

> *Therapist: …but it's an **extremely deeply** held belief, is that, every time that he starts to feel that way, to feel worthless…*

> *Therapist: NOW at this particular time, do you **really** believe that at this time in your life, you're **just** a push=over and weakling, like you were when you were a kid, are you a mammas' baby or not?*

> *Therapist: I **always** get them to look at their beliefs…*

The function of this terminology was to make the positions the therapists were advocating more convincing. This increased the strength of their accounts, ensured that their versions prevailed, and in turn helped warrant their expert status. However, at times it also seemed that some of these formulations pushed the "horizon of the intelligible" (Wetherell, 1999, p. 268). For example, this was demonstrated by the client's body language, such as the raising of eyebrows or squinting, and posed a direct threat to the therapist's expert status.

Concealment.

A third discursive strategy involved therapists concealing their own personal views and knowledge in order to reinforce their expert status. In this case, what was not said turned out to be just as important as what was said.

For example, throughout the transcripts therapists never revealed or acknowledged what they themselves believed, even when directly questioned:

> *Client: Is that, kind'a, what **you** believe?*
> *Therapist: What's important is that you…*

To reveal or acknowledge would have potentially jeopardised their positions as experts, as it would have allowed the possibility and opportunity for criticism, and thus the weakening of their status. This absence was particularly noticeable as in this relationship, perhaps more so than in any other professional relationship, the client would have benefited from direct modelling and learning about more pleasurable and functional beliefs. Instead, however, therapists seemed to personally portray themselves as perfect, almost omnipotent.

A MORAL REPERTOIRE

The use of a moral repertoire involved the therapists drawing on and using moral terminology and notions in their interactions with their clients while in the expert subject position. In this repertoire therapists constructed moral notions of both belief and of persons. With regard to beliefs, there was the 'right kind of beliefs' for the client to hold. This element can be discerned in the following extracts:

> *Therapist: …they just don't know what's really **bad** about the beliefs they've got.*

> *Therapist: …there are **better beliefs** than these, these beliefs just aren't **right** for them.*

With regards to persons, and as a consequence of having the 'right kind of beliefs', there was a striving to be a 'good' or an 'ideal' person. This can be discerned in the following extracts:

> *Therapist: Well, it's not really what you **would want** to believe. That's not gone'a get you to where you **need to be**.*

> *Therapist: …this more functional belief would be **good** for **her**.*

Although the vast majority of moral references were about or directed towards the clients, and indeed this repertoire mainly operated between therapist-client interaction (i.e., not so much therapist-therapist interaction), the implicit implication seemed to be that therapists had obtained or knew of 'the better life', and could thus qualify as 'ethicists'. By drawing on this normative and prescriptive way of talking, therapist worked up and positioned themselves as moral 'experts'.

THE FUNCTION OF THE STRATEGIES AND REPERTOIRE

As a whole, the use of these discursive strategies and this repertoire strongly put the power of the relationship in the hands of the therapist; even though cognitive therapy is supposedly a collaborative process and

relationship (Persons et al., 2001). For example, once established, the expert position granted therapists a paternalistic ‘licence to confuse’ their patients. Similar to the way doctors regularly converse in medical concepts and terminology beyond the level of comprehension of their patients, in which the patient usually acknowledges and accepts, although does not understand, the terminology or concepts, therapists conversed in concepts and terminology beyond the level of comprehension of their patients. This subtle paternalism evident in a doctor’s non-explanation of complex medical terminology could also be seen in various aspects of the therapists discourse, for example:

> *Therapist: …the tightening of your* ***intercostal muscles*** *lead to a fear of not being able to breathe*.

However, interestingly, this ‘structure of rights’ entailed by the two positions also seemed equally agreeable to both parties. The regular uptake of both of these positions in actuality laid much of the foundation for the therapeutic process and subscribed the possibilities for and limitations on various actions. Hence, these subject positions had considerable implications for the power relations between the therapist and client, as they constrained and shaped to a large degree what was possible in their therapeutic relationship.

For the client, there seemed a number of advantages to adopting such a position. Foremost amongst these were the offset of responsibility onto the therapist to care for the client, and positioning themselves in a more malleable position from which to allow therapeutic change. For the therapist, there also seemed a number of advantages to adopting the expert position. Foremost amongst these were the instilment of certain powers and responsibilities to act in a beneficent and non-maleficent way, and the clarifying of boundaries surrounding what was and could be expected.

Caveat emptor: Three points.

Firstly, the subject positions adopted were particularly hard to discern given the different types of media and interactional formats utilised. For example, the identities negotiated seemed slightly different when therapists were conversing with other therapists (such as in the instructional books), as compared to conversing with clients (such as in the video demonstrations). Compounding this element, and as would be expected, the subject positions adopted also varied as therapists’ talk changed as a function of their particular contexts and what they were trying to achieve in particular instances.

Secondly, we have chosen to focus on and present the two most frequently adopted subject positions (‘expert’ and ‘layperson’) discerned in the various texts. However, in addition to these, both the therapist and client also adopted a number of other interesting subject positions. These included the therapists adopting a ‘friend’ position in which they befriended their clients, and a ‘nursing’ position in which they cared for their clients. Clients also adopted a ‘teachers favourite’ position in which they sought special treatment and attention from their therapist, and a ‘hopelessness’ position in which they resisted their therapist. Nonetheless, these positions were not covered in this article.

Lastly, bear in mind that information in this article is extracted from, and is a back drop to, a larger research project which investigated how the notion of belief is constructed and used within the cognitive therapy domain.

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