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Therapeutic discourse, co-construction, interpellation, role-induction: psychotherapy as iatrogenic treatment modality?

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Abstract *The objective of this paper is to build a convincing inductive argument as to how psychotherapy might be said to discursively produce psychopathology. Focusing closely on the technical workings of what is ultimately termed a 'psychotherapeutic technology'—that is, a set of applied clinical skills, techniques, strategies, and specialized forms of knowledge and language utilized by the psychotherapist—the author conducts an empirical grounded theory analysis of a sequential series of psychodynamic psychotherapy sessions, conducted and published by a well-respected practitioner. On this basis, the author makes a series of claims which centre around the interpellative, role-inductive and authorial prerogatives afforded therapists by the therapeutic process, prerogatives which provided them with constructive latitude enough to discursively generate psychopathology within patients' accounts of themselves. The 'pathogenic' nature of this process, along with the tactical and technical abilities afforded therapists in order to 'discover' psychopathology, furthermore lacked a balancing set of controls. This mix of such a powerful technology of intervention, without a reasonable (or patient-centred) set of counters and balances, means that psychotherapy comes dangerously close to being a constitutively iatrogenic form of treatment.*

Introduction

In recent decades several critical strands of thought have argued that systems of knowledge do not simply *name* their objects of study, but in some sense *produce* them. In a similar vein, this paper begins with the suspicion that psychotherapy is just as able to *produce* as to *detect* psychopathologies within its patients. To argue that psychotherapy has such a productive power is obviously to assert a serious ethical dilemma for clinical practice. Indeed if this naming/detecting distinction is in fact unstable, then psychotherapy may be implicated in generating exactly the problems it has apparently been designed to treat. This paper will take up this argument through an empirical study of the pathologizing tendencies of *en vivo* psychotherapeutic practice.

It is important to make several qualifications at this point. First, to argue the collapse of this basic production/naming distinction is not to contend that the only psychopathologies dealt with within the psychotherapeutic realm have been generated by virtue of psychotherapeutic participation. (For the purposes of this argument, it may be acknowledged that instances of psychopathology pre-exist entrance into psychotherapy.) Similarly, to claim that psychotherapy is just as capable of producing as of detecting psychopathology is not to

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suggest that psychotherapeutic involvement never results in therapeutic or 'healing' effects. In arguing about psychotherapy's ability to produce psychopathology, I do not mean to suggest that therapists are having some kind of toxic psychological effect on their patients, and that exposure to this form of treatment will almost inevitably result in a kind of psychological damage to such patients. In this connection it is vital to clarify that the argument being made here is about psychotherapy's *discursive* ability to produce psychopathology within patients as a function of the way in which it *organizes knowledge*. This is opposed to arguments that assert that it is *the psychological mechanisms* of therapy that cause harm.

It is, however, important not to underestimate what is meant by the discursive. Discourse here will be understood as entailing both textual *and material* elements which have real effects on the world, on the levels of *knowledge* (in both its formal institutional and popular, common-sense capacities), *subjectivity* (with its correlating questions of identity and self-understanding), and *action* (implicit or explicit prescriptions to action or even regularized practice). To speak of *producing psychopathology* is hence to refer to a discursive function which entails powerful knowledge, subject and action effects. In speaking of psychopathology, furthermore, the author is using the term in a relatively loose manner, not exclusively in the sense of what might be taken to be a clinically coherent syndrome or disorder, but as a broad and inclusive category of psychological difficulties or disturbances, much in the sense of Szasz's (1984) notion of 'problems in living'. In short, the term is employed here in the sense of psychological or emotional concerns *as identified or recognized by a clinician as a reasonable and sufficient working focus of therapy* (cf. Szasz, 1984).

Methodology

The argument presented here stems from a larger study into the general functioning of power in psychodynamic psychotherapy (Isack & Hook, 1999). Adopting an empirically-grounded approach, this study maintained a strong focus on how the discursive production of psychopathology was *technically* managed within psychotherapy.

This study analysed 250 pages of published transcriptions of therapeutic dialogue using a constructionist revision of Glaser and Strauss's (1967) grounded theory method of analysis (cf. Pidgeon, 1996; Pidgeon & Henwood, 1996). The grounded theory method provided a 'data representation language'; an open-ended indexing system that enabled the researcher to work systematically through a basic data corpus, generating codes referring both to low-level concepts and more abstract categories (Pidgeon, 1996). Likewise, the constructionist aspect of this grounded theory method enabled the researcher to draw on discursive forms of analysis, to utilize elements of the grounded theory method in a deconstructive way, to insert new discourses into old systems of meaning, and to ultimately remain vigilant regarding the *constructed* rather than *transparent* nature of analysed protocols (cf. Pidgeon, 1996). Importantly, although a variety of published texts were drawn upon in the original study, in the interests of maintaining consistency across *this* representation of clinical interaction, the examples employed here all stem from a single source: a sequence of nine consecutive psychodynamic psychotherapy sessions as published by Wolberg (1977) as illustrative of exemplary therapeutic practice. This no doubt limits the generalizability of the findings of this research, but by the same token, it makes for an interesting case-study application of a critical hypothesis within a delimited data body. One should bear in mind also that this research did not aim to definitely resolve the issue at hand; grounded theory research is by its nature tentative, as Glaser and Strauss themselves (1967) assert: the findings of a grounded research project are exactly that, a strong hypothesis in the data.

Now whilst the results of this study *did* suggest that psychotherapy *could* be said to discursively produce psychopathology, they also suggested that this production was

achieved in no one single way, instead being found at the confluence of a number of therapeutic 'functionings'. Accordingly, this presentation will critically describe several aligned therapeutic functions, ultimately offering an 11-point argument which brings together the relevant 'faculties' of psychotherapy enabling it to 'produce psychopathology'.

Therapeutic listening

One of the most obvious psychotherapeutic functions performed by therapists upon their patients was the basic act of *listening*. Despite the 'even-hovering' appearance of therapeutic listening, this phenomena functioned as a strongly directing and focusing activity that filtered and hierarchized incoming data into categories of varying importance. Cross-sectional comparisons across the data yielded a variety of similarly motivated questions (posed by therapists) in early sessions, suggesting that therapists were listening more intently to certain aspects of patient's narratives than others. Similarly, clear evidence of diagnostic and etiological 'priorities in listening' (along with high premiums on types of patient disclosure) was traced by mapping and grouping types of therapists' questions within early sessions. Furthermore, therapists' interruptions to material deemed less relevant or unimportant to the therapeutic value of sessions likewise functioned as indices of the directing and focusing functioning of therapeutic listening.

As such, therapeutic was characterized *as a purposeful and goal-driven form of action* marked by purpose and intent. Comparative analysis suggested that psychotherapists, like priests and doctors, were professional listeners, typically involved in more than a purely passive and facilitative activity when 'listening'. Upon close scrutiny, and with the correlation of attending activities and therapeutic goals, it became clear that therapeutic listening frequently functioned as an auditory form of inspection, a means of observing, assessing, monitoring; an auditory surveillance designed to develop patient disclosure.

Like the doctor's gaze, which yields knowledge and prescriptions of intervention from the visual analysis of the injured body—which imposes discourse upon the act of perception, as Bryson (1993) puts it—so the attentive ear of the psychotherapist brought with it certain values, understandings and knowledges to be implemented within the therapeutic setting. Although these professional knowledges, values and clinical norms remained for the better part *unspoken* by the therapist, they were omnipresent in *how the clinician practised their listening*.

Eliciting disclosure, 'externalizing conscience'

The 'force' of therapeutic listening was enhanced in a variety of ways. The concentrated performance of an *interested* and *attentive* presence, was, for example, an important factor. By 'communicating presence' and providing tacit indications of acknowledgment, encouragement and support, this 'listening function' was able to elicit *more personal* forms of disclosure. This was particularly the case when such listening was used in conjunction with the provision of an authenticating environment and the diligent 'tracking' and non-verbal reflection of emotions. These authenticating variables, once paired off with implicit forms of support, unconditional acknowledgement, and the camaraderie of the 'working bond' of the relationship, made for a strong sense of trust which in turn was an essential factor in 'soliciting' the most private and shameful disclosures.

The 'clinical gravity' of the therapeutic situation was also an apparent factor, the very presence of a professionally-qualified expert of psychology paid to attend to the patient appeared to have played a role in insidiously 'soliciting' their disclosure. The combination of these various techniques and frame elements proved extremely successful in

eliciting not only intimate personal expositions, but also in encouraging various patient 'confessions'—of 'sinful', 'wrongful' personal feelings or desires, of deviant or 'unacceptable' wishes, habits, and peculiarities. These were powerful emotional admissions of deviant or shameful intentions/acts offered up to a psychological expert seen as being able to properly make sense of and/or treat such 'problems'. The regularity of this phenomenon across protocols was both striking and difficult to account for, as was the seemingly *automatic* nature of this 'confession-making'. Indeed, this near unfailing tendency of patients to disclose their most deviant or shameful acts, and to then implicitly relate them to current norms or standards of right/wrong or normal/abnormal, soon came to represent something of an explanatory crisis for the researcher.

Part of the frequency of this phenomena seemed to lie in the fact that patients generally assumed (and often quite explicitly so) that the therapeutic environment was an evaluative space, a place where their normality would implicitly be assessed. Often this assumption accounted for patients' anxieties about entering psychotherapy, and therapists often needed to expend a good deal of effort trying to persuade patients to the contrary. Whatever the case may have been, it soon became apparent that these confessional forms of 'externalizing conscience' were a powerful characterizing feature of what was generally deemed effective psychotherapy. Ultimately, the only reasonable hypothesis that the researcher could mount, within the frame of the data itself, was that one of the prime functions of eliciting personal disclosure, through various combinations of technique and context, *was precisely to displace a form of normative self-evaluation within patients*. This 'displacement' of normative evaluation remain was substantiated by the numerous times it recurred within the data body, and by the ways that patients so repeatedly tested their evaluative assessments against the opinions of the clinical expert.

The important point here was that this displacement of normative self-evaluation did not proceed explicitly, directly or exclusively from the therapist. This point will be discussed in further detail as we proceed; given the regularity and the seeming strength of this phenomena however, we can nonetheless assert the first strand of our argument: *psychotherapy functions to elicit, with impressive regularity, and through non-directed or explicit means, a powerful gravity toward normative self-evaluations on the part of its patients*.

As is apparent in the above example however, and as borne out in the results of the analysis more generally, such self-evaluative procedures occurred not only *indirectly* through the '*inactive' influence*' of they psychotherapist, they occurred moreover on the apparent basis of the patient's *own initiative*, sometimes in response to the therapist's apparent non-judgemental attitude. Indeed, what the data suggested was that the 'surveillance' of therapeutic listening, together with patients' understandings and expectations of the role of the clinical professional, seemingly displaced *within patients* an implicit leaning towards normative values and standards. The effectiveness of this displacement was that it was the patient who ultimately really situated *themselves* relative to social and moral values. To the first strand of the argument we may now add a second: *this gravity toward self-evaluation quickly becomes an automatic function within psychotherapy, occurring largely on the basis of the patient's own initiative and responsibility*.

Self-attendance, 'therapeutic talking', patient 'subjectivization'

If listening was one of the most basic therapeutic functions performed by therapist, then talking was certainly one of the most basic therapeutic functions performed by patients. Cross-protocol comparison across the data pool revealed a relatively unexpected result concerning this 'therapeutic talking' of patients: although frequently *apparently* disordered and rambling, this talking was ultimately a cohesive and directed activity, unified by a

number of strongly characterizing and structuring features. The first such feature of these 'talkings' was that they were powerfully 'egocentric' and self-focused.

At its most basic, the therapeutic talk of patients was that of a personal story, a personal narrative, of which they were both author and protagonist. In this way such narratives were marked by a fundamental self-attention, a strong '*I*' foundation and pivot. Indeed, a central component of these self-attending 'talkings' was the provision of a reflexive attitude that, whilst often vague at first, soon grew in strength. This self-focus was in many ways the outcome, again, of the 'inactive intervention' of therapists, who, through explicit refutation of typical conversational structures, and through their strong prioritisation of patient subjectivity, came to discretely promote and encourage this self-attending orientation.

Inappropriate questions, personal enquiries and overly result-based queries were gradually extinguished by the therapist's avoidance of providing answers, or by their 'bouncing back' of patients' questions in the form of personal probes. Both of these tactics resulted in the encouragement of a strict and personal self-attending focus for the patient. As therapy progressed, therapists 'slimmed down' their contributions to a bare minimum, enforced a guarded and tactical form of detachment such that the therapeutic narrative came very close to approximating the therapeutic monologue of the self-monitoring patient. This combination of continual re-direction and strategic disinvestment made patients increasingly self-reflexive and independent. Patient self-awareness was further encouraged by therapists' encouragement of patients' subjectivity. In fact, at each point of the therapeutic narrative the 'egocentricity' of the patient's narrative was supported and reinforced, such that the focus on self and self's problems was soon the vastly predominant, and speaking relatively, *only* real concern within the patient's narratives.

The use of prescribed or generic answers/responses of the '*this must be difficult for you*' variety likewise served to keep the personal involvement of the therapist to an absolute and clinical minimum whilst simultaneously facilitating the narrative emergence of the *subjective*, *personal* life of the patient. The re-use of large segments of the patient's descriptions, of their own words and terms of understanding, similarly ensured that the therapeutic narrative was, at times, essentially a monologue, essentially the narrative of *one* voice, that of the *subjective patient's*, even if it was repeated, re-emphasized, or extended by the therapist in ways which structured or directed the session. Take the following example, in which the therapist explicitly directs the patient towards a self-monitoring and (emotionally) self-aware form of narrative:

> *Pt.* … I've had some disappointments … I took an interest in helping crippled children … Normal children hurt little children, you know … I feel badly about it, but I don't think that has anything to do with … what's happening to me.
>
> *Th.* There are other things?
>
> *Pt.* It goes further.
>
> *Pt.* It goes further? It involves your own feelings about yourself? (Wolberg, 1977, p. 1052)

As evidenced in the above extract, the accessing and reinforcement of subjectivity also occurred through therapists' continual querying of the personal opinion of patients. Typical of this tactic was the therapist's redirected retort to a direct question: 'But what do *you* think?' More simply: 'Do *you* have any idea what causes these feelings …' (Wolberg, 1977, p. 1050, my emphasis). The patient's comment: 'It's how I feel about myself that really counts' (Wolberg, 1977, p. 1081) provides evidence of this kind of therapeutic effect, as does the comment: 'Ever since I've been coming to see you, I've been giving more thought to myself

than I've ever done in my whole life' (Wolberg, 1977, p. 1079). A useful adjunct here was the emphasis of the words used to reference the patient, the vocal italicization of the patient's name, of mentions of 'you': 'But how do *you* feel?', 'And then what did *you* do?'

The placement of such a premium on the development of patient subjectivity and reflexivity was a strong and unremitting pattern throughout therapeutic protocols. The patient's *self* increasingly became a level of awareness and a surface of intervention that needed to be prioritized; more than this it became the vessel through which therapists could repeatedly appeal to the patient's agency, to *their* own personal prerogative, and responsibility, to change. This was a fact which led the researcher to conclude, and this is the third strand of the developing argument, *that an essential factor of therapeutic involvement is the powerful foregrounding of patient subjectivity and agency as fundamental bases from which psychological problems needed to be approached.* In short: *instrumental to psychotherapy is the systematic assertion, within patients, of practices of personal reflexivity*.

Speaking the role of therapist; therapeutic questioning

An interesting correlate to the therapeutic objective of patient 'subjectivization' was that of encouraging the development of an 'auto-therapeutic' narrative on the part of patients. By virtue of the above-mentioned clinical minimisation of the personal or conversational input of the psychotherapist, the patient frequently appeared to take up both (patient and therapist) roles in the dialogue, thus becoming both author and evaluator of their own dialogue. Take, for example, the comparison between the questions a patient asks her psychotherapist in their second session, and a comment she makes in her ninth session, respectively:

> *Pt.* I would like you to tell me what is wrong, doctor … (Wolberg, 1977, p. 1050)
>
> *Pt.* My big problem … is what I do to myself because I feel no good. (Wolberg, 1977, p. 1098)

Such a shift in the focus of the therapeutic narrative, and in the locus of attention and responsibility, is, typically, viewed as evidence of therapeutic progress. Similar longitudinal comparisons across protocols suggested that patients' narratives increasingly mimicked the form of the therapist's vocal contributions. Taking on the speaking function of the therapist, not only in content, but in structure and impetus, the patient, almost unfailingly, started to 'speak their role', started to conduct the facilitative, explorative and 'knowing self' therapeutic functions autonomously. Streamlined through the excision of superfluous detail, the avoidance of therapist-directed questioning and the adoption of accurately aimed self-examination and scrutiny, the 'talks' of patients in late stages of therapy came increasingly to be 'auto-therapeutic', to perform their therapeutic lessons:

> (The patient is speaking of a previous dysfunctional relationship)
>
> *Pt.* Do you see? He … keep[s] on dabbling with … women … I say 'Yes, all right, I'll be here; all right, I'll see you.' And as soon as I say it, I *know* I shouldn't have said it. I know I'm wrong. I know I'm being too soft, too easy about things … Do you understand? … You see? I say 'Yes' or 'All right, I'll do it,' and if I say I will, I'll do it, no matter what. But I shouldn't. I should be very careful of what I answer and what I say … There'll be a lot of opportunities, but I must watch out not to start anything with someone—well, a man who isn't deserving: and I'm not going to get involved, no matter what demands are made. (Wolberg, 1977, p. 1098)

In the above example the patient in fact even appears to be *instructing the therapist* by

continually querying whether he follows *her* self-instructions. This adoption of the narrative structure previously lent by the therapist frequently ensured that patients were able to motivate and guide their own treatment with a relative amount of independence; similarly patients often, at this point, began to lead their own narrative with questions of a self-probing nature. Furthermore, patients often came to provide self-assessments, self-recommendations and personal suggestions of reparative behaviour.

A similar example of the patient taking on therapist functions is seen in the 'therapeutic corrections', the verbal amendments made by patients to their own narratives. Dysfunctional trends and directions within their typical narratives were gradually, systematically eliminated and became the subject of patient's reflexive criticisms, where they were able to identify such recently highlighted 'dysfunctions' and vocally check their 'mistakes'. Hence we can assert the fourth strand of the developing argument: *the apparent effect of this form of patient narrative was the 'installing' of a therapeutic subject-position through which a relentless and seemingly automatic habit of self-problematization (and self-correction) was instituted in an internal and subjective manner*. Fifthly: *this therapeutic subject-position appeared to be so firmly and durably entrenched at the level of individual and personal subjectivity as to exert its influence beyond the parameters of the therapeutic setting*.

Another core function of the psychotherapeutic arena was the therapist's tactical use of questioning to ensure the continual outflow of patient disclosure. Indeed, cross-protocol comparisons quickly revealed what had been suspected, that therapeutic questioning (along with a variety of associated techniques like prompting, redirecting, reflecting and 'echoing sentiments') often clustered around the querying of relational, personal, historical, symptomological and emotional details. Each of these areas represented a strong potential location-point for indications of psychopathology. The use of an unbroken sequence of related questions, the building up of a 'momentum of enquiry', for example, was not only inevitably successful in invoking disclosure around these relevant 'location-points', but it also yielded, almost without exception, a potential 'node of pathology', a working focus or problem area that the therapist could continue to probe for further evidence of psychopathology. This tactic was particularly useful with resistant patients; take, for example, the following extract from the therapist's first session with a new patient (note the therapist's leading question):

Th. Would you like to tell me about your problem?

Pt. (rapidly and angrily) The first thing I'm going to tell you is that I am against psychotherapy …

Th. Why?

Pt. Because of my past experience. I'm coming here against my will.

Th. I see.

Pt. Definitely against my will.

Th. Can you tell me about that?

(Patient relates anecdote about unsuccessful psychotherapeutic experience).

Th. Well it does sound like you had some ungratifying responses.

Pt. The first doctor wasn't really a psychotherapist …

Th. How long did you go to him?
Pt. Just a few times … it wasn't doing me any good.

Th. What was the reason for going to him in the first place?

Pt. I was kicked out of school.

Th. College? (Wolberg, 1977, p. 460)

This tactic was also useful where no discernable problems seemed to be evident:

Th. Are you completely satisfied with your present life and adjustment?

Pt. Yes.

Th. It's very gratifying to be so well satisfied. Understandably you wouldn't want any treatment if there is nothing wrong.

Pt. No.

Th. Your mother thinks you ought to get treatment. I wonder why?

Pt. I don't know.

Th. Maybe you're angry that she sent you here if you don't need treatment.

Pt. I'm not angry.

Th. Mmm. (pause) But there must be some area in which you aren't completely happy.

Pt. Well … (pause)

Th. Are you satisfied with the way everything is going in every area of your life?

Pt. (pause) No, not exactly.

Th. Mm hmmm. (pause)

Pt. It's that I don't go out much, not much, I don't go out with boys … (Wolberg, 1977, p. 463)

In the last extract the therapist comes very close to using the patient's very resistance to the process as the motivating reason for why she should be there, and manages this through the questioning of her prospective anger. Here a sequence of questions was compounded with the use of a rhetorical trick—which forced the patient into admitting that there may have been at least one thing wrong with her life. (Indeed, few people would be able to claim that they are satisfied with 'the way everything is going in every area of your life'.) Questioning techniques such as this added significantly to the therapy's ability to *construct* rather than merely *discover* psychopathology. In fact, rhetorical tricks seem 'par for the course' in the therapeutic attempt to 'unearth' psychopathology within patients. Indirect or oblique patterns of enquiry, for example, were effective in preventing patients from guarding against aspects of the information they imparted. In probing for aetiological and diagnostic information, therapists would typically avoid asking 'point-blank' questions with yes/no answers which would risk incidentally cueing patients in on what *not* to say. The request 'do you dream a lot or a little?', was, for example, preferred by Wolberg (1977) to the more direct 'do you dream?'

In attempting to ascertain accurate symptomological details, therapists very seldom asked outright or blunt questions, but approached the characterization of problem areas far more obliquely, picking up on certain trends and tendencies *already mentioned by the patient*. '[W]as there ever a period when you felt happy?' (Wolberg, 1977, p. 1045), for example, was an effective means both of tacitly asserting a presenting 'problem' and of 'closing down' the

patient's ability to avoid discussing what the therapist later construed as a state of depression. Various other forms of indirection, such as that of peripheral questioning, of juxtaposing placid and provocative enquiries (or obvious with investigative questions), were frequently used in conjunction with the tactical reconstruction of patients' own words. All of these techniques 'opened up' the therapeutic dialogue, made it easier for the patient to converse freely, and provided questions which were immanently more answerable than directed queries which risked being prescriptive. By the same token, however, the use of these techniques also made it far harder for patients to guard *against* providing the kinds of answers that could be reconstructed as potential indications of psychopathology.

Happening in the absence of a set of 'control' questions whereby contrary representations and depictions may be actively sought—whereby seemingly pathogenic qualities may be refuted and denied—such forms of therapeutic questioning ran the risk of directly soliciting the kinds of accounts they wanted to hear. In this respect the researcher found it difficult to determine whether psychotherapy was a probing process of discovery, or a 'calling into being'; a balanced testing for psychopathology, or a selective collection of the basic 'building blocks' from which to gain the necessary 'corroborating evidence' to build a picture of psychopathology. More concerning yet, the 'problem-centric' nature of these lines of enquiry could not but beg the following question: *could the therapist ever fail to find what was being looked for?* We may hence assert the sixth basic strand of this argument: *therapists appear to have at their disposal a variety of rhetorical and questioning abilities, that, along with their ability to reconstruct patients' own accounts, provides them with a broad constructive latitude with which to generate certain 'nodes of psychopathology'*. Seventhly: *the 'problem-centric' nature of the process, along with the tactical and technical abilities afforded the therapist in order to 'discover' psychopathology, lacks a balancing set of controls to the extent that the psychotherapeutic search for pathology frequently resembles a 'look hard enough and you'll find what you are looking for' scenario*.

Co-construction of therapeutic accounts, interpellations of meaning and emotion

The possibility that therapists exercised certain constructive powers within the therapeutic arena came to represent an important analytical focus for the researcher. Indeed, despite having asserted earlier that the patient's therapeutic narrative was at times essentially that of a monologue contributed to and supported by the therapist's redirected and structuring use of the patient's *own* therapeutic voice, it is important to point out that the therapeutic narrative also frequently took the form of a *dialogue*, in the true sense of being made up of, and constructed by, *two* voices.

Despite the fact that therapists attempted to cultivate the development of autonomous, reflexive 'self-dialogues' within patients, they never lost their directing function within the therapeutic interaction. The therapist's use of unfinished or trailing sentences, for example, was frequently leading, not only in terms of directing the patient's exposition, but also in terms of suggesting *what* they may say. Indeed, sometimes the exact words are offered by the therapist that are then picked up and used the patient:

> *Pt.* … instead of building me up, you see … he always … (pause)
>
> *Th.* He always minimized …
>
> *Pt.* Minimized my ability, my thinking capabilities. (Wolberg, 1977, p. 1078)

At other times emotional descriptions were made stronger, or were 're-sited' within the 'subjective subject' of the patient:

Pt. … I crossed myself up with this man … Three and a half years I went with him … and he hasn't called me … months …

Th. You resented the fact … (Wolberg, 1977, p. 1066)

Pt. I'm afraid of being hurt.

Th. You're afraid of being hurt. Rejected? (Wolberg, 1977, p. 1067)

Whether it is through the offering up of a pinpointing emotional term that carried a resonance which the patient then went on to adopt, or whether it was the case of the therapist's introduction of a *new* term, with a different weighting of meaning altogether, either way, the therapist appeared to play an active role in co-constructing the meaning of the therapeutic narrative. Although generally accurate in a reflective manner, such comments nonetheless effectively narrowed down what the patient could say, and 'streamed' the therapeutic narrative toward a certain destination of meaning.

The use of probing, pinpointing or narrative-generating words or half-sentences involved an important interpellative function, in the sense that it 'hailed' or called patients to answer or complete them, in ways that they could not resist, or, perhaps more accurately, decline to answer (cf. Althusser, 1971). It is important here to briefly distinguish the notion of construction from that of interpellation. Whereas construction, for the purposes of this chapter, refers to the discursive generation of *meaning*, interpellation refers to the tactical *positioning* of the subject by virtue of which *they* are made to actively adopt and extend the influence of power *over themselves*. So whereas the notion of construction prioritizes the production of *discursive meaning* as an outcome of power, interpellation prioritizes certain subject-positions, certain roles and their attendant *behaviours*, as the outcome of largely irrefutable forms of influence and suggestion.

More than simply co-constructing patients' therapeutic narratives then, psychotherapists could be said to have played a part in *interpellating* the meanings of patients' therapeutic narratives by making compelling and largely irrefutable contributions to the development of these accounts of self. Indeed, despite the fact that some latitude was granted patients in exactly how they picked up on such contributions, the point is that, practically speaking, within the therapeutic encounter, they *had* to be picked up. This was not simply a case of the therapist 'putting words into someone's mouth', because the patient could, and at times did, refute such meanings. It was, however, a case of the therapist bringing meaning into the session, which, once introduced, could not be simply ignored, removed, 'undone', 'voided'. The patient had in some ways to 'take these up', to confront them, to take them into account and/or integrate them within the context of the present therapeutic narrative, and in the context of their own developing self-awareness, even if that was to mean the making an apparent rejection.

Such interpellative comments were introduced in a number of ways. The use of an 'echoing voice', of reflection, of forms of synopsis and summary, all played a role in delineating and narrowing the therapeutic narrative. Such a 'narrowing' also occurred through the re-inflection of meanings, and through 'checks' of meaning. This interpellation tended to occur most effectively once it had taken the form of hypothesizing about the patient's motives and emotions, for example. The general 'murkiness' of emotions, their overlapping qualities, their lack of clear-cut distinction, and the way they lend themselves to distortion over time made them easy targets for the interpellative powers of the psychotherapist. Take, for instance, the struggle of emotional meaning contained in the following extract:

(Speaking of the man that a friend recently married):

Th. Does he appeal to you at all?

Pt. To be married to? No.

Th. Not at all?

Pt. Well, he's nice. I like him, I respect him, but for marriage, no.

Th. There's no jealousy at all?

Pt. No, not at all.

Th. No envy of this woman?

Pt. No, no. Why, did you feel there might have been?

Th. Well, I don't know. I'm just thinking about that dream … […]

Pt. Well, I …

Certainly a fundamental factor in the therapist's 'warrant' to make emotional attributions in the extract above was the very ambiguity and instability of emotions once retrospectively reconstructed. This example is useful in another way also: it makes clear the extent to which therapists maintained a powerful authorial privilege in the therapeutic narrative. (In fact this would seem an intrinsic quality of psychotherapy, given the assumption that therapists are able to detect meanings and emotions in patient's narratives that may in fact remain hidden to patients themselves.) This authorial privilege is clearly evidenced in the above example when, despite her own repeated denials, the patient eventually asks the therapist whether *he* thought she may have in fact been jealous despite her feelings to the contrary. The important point here is that such interpellations may be thought of as having an impact on the level of *patient subjectivity*, on the ways and means in which patients continue to gain self-understanding, and on the dispositions to behave and act which stem from such 'therapeutic' realizations.

The interpellative powers of the psychotherapist also appeared to include the capacity for a form of emotional influence. Typically reflective statements, like 'cueing' prompts, whilst generally accorded an empathetic value, appeared to possess a more complex interventional value. Analysing such reflective comments not merely on the basis of their clinical meaning, but on the linguistic basis *of the action of language in use*, the researcher found that such responses were a strong way of *enforcing emotional experiences within patients*. A key tactic in this regard was the use of pinpointing emotional terms that refined the patient's given meaning and that were unconditional and direct in their identification of strong labels for evidenced emotions. Such terms were often more extreme in degree than the words the patient was using, so as to highlight, in an unremitting way, the power of underlying emotions, to ostensibly therapeutic ends.

As an example: when a patient offered that she was left without support after her husband and sister died, the therapist retorted, probingly, that she felt 'totally isolated' and 'alone'. Similarly, when a patient said she felt empty and without hope after a certain unfortunate event, the therapist distilled this meaning by 'reflecting' that she felt 'devastated'. More than supporting a growing emotional reality of meaning, this kind of reflection/repetition/re-inflection possessed a rhetorical 'irrefutability'. Like rhetorical questions that require no answer, and that are designed and directed primarily at making an effect, rhetorical statements of this sort kept the patient's 'manoeuvring room' to a minimum, and effectively closed down the patients ability to differently position themselves in relation to the reality of the developing therapeutic narrative.

In this way, more than simply being vehicles of empathy or reflection, these kinds of statements had an *accentuating* function that furthered meaning and amplified it in the

direction pursued by the therapist. In a sense then it is true to say that therapists were able to 'make their patients cry', to steer them, where deemed clinically effective, into provocative emotional terrains, and to elicit strong, actual, *in vivo* emotional responses. Take, for example, the following extract, in which the therapist 'built the patient up' with reflective comments, and then pinpointed a lack in her life with the focused and tactical use of questioning:

> *Pt.* … I've been going a long time with these people … And I feel as if I'm neglecting them if I don't call … Isn't it awful?
>
> *Th.* It must be kind of tough for you.
>
> *Pt.* It is. It really is. You see what I mean.
>
> *Th.* Do you think you need a few new interests?
>
> *Pt.* Well, there's no question …
>
> *Th.* Have you ever done anything—hobbies, art, anything?
>
> *Pt.* No, all I've ever done … is work at our book business … You do that for 22 years, and then. I couldn't stand it any more.
>
> *Th.* Apparently it was more than you could stand.
>
> *Pt.* That's why I got out of it. (cries)
>
> *Th.* You've suffered a great deal. (Wolberg, 1977, p. 1053)

The therapist here has made use of a kind of unrelenting reflection, a confrontation of the patient with the powerful emotional reality of the presenting problem. It is this special 'focusing' that appears to have 'broken the wall' for the patient and brought a formidable level of emotion to the fore. The therapist hence appears instrumental in both the construction *and the interpellation* of the patient's therapeutic narrative. The psychotherapist is participant both in the discursive production of certain meanings within the therapy session, and in the active positioning of the patient in relationship to the 'irrefutability' of a variety of co-constructed meanings, emotional values and experiences.

Therapeutic 'role-induction'

A further means of interpellation that therapists had at their disposal was that of 'role-induction', i.e. the ability to ensure that patients adopted appropriate 'patient roles' and corresponding responsibilities in the clinical setting. Such a role-induction appeared in fact to have underscored many of the researcher's earlier observations, particularly with reference to the typical willingness and appropriateness of patients' participation (and investments) in psychotherapy. The extent to which patients seemed so active, so 'obedient' and in fact *proactive* in their therapeutic treatment made for an intriguing analytical challenge for the researcher.

The notion of interpellation again proved helpful here, particularly in the sense of *a role-interpellation* in which the therapist would, in multiple ways, position their patients *as patients*, by never interacting with them in any way that might exceed the patient–doctor relationship. The notion of such a form of interpellation, namely, role-induction, enabled the researcher to account for the readiness and appropriateness with which the majority of patients took to the patient role.

Similarly, it helped explain how patients seemed to so naturally structure their therapeutic narratives around self-attending and problem-centred focuses (not to mention the readiness

and frankness of the often personally-compromising disclosures made by patients within treatment). Furthermore, this notion of role-induction also helped explain how a variety of frame-elements could be so vitally mobilized by therapists as *functional aspects* of the therapeutic work.

This role-induction hypothesis was arrived at by a variety of cross-sectional comparisons of type-type role behaviours across the progress of psychotherapy. To use a familiar example, the concerted performance of '*therapeutic listening*' by the psychotherapist was typically enough to elicit, and be accompanied and matched by, the appropriate therapeutic response of *personal disclosure* on the part of patients. Similarly, the therapist's role of *authoritative interpreter* was typically enough to elicit, and be matched by, the appropriate role of *attentive learner* on the part of the patient, just as the patient's role of *expositor* was marked, conditioned and elicited by the therapist's role of *empathic facilitator*, and so on. Just as therapeutic constructions of meaning were contributed to by both 'partners' of a dialogue, and were hence indivisibly mutual, so the acting of appropriate therapeutic roles, whilst largely initiated and controlled by the therapist, were similarly mutual, interdependent, and mutually constructive. Basically, such pairing relationships, such role-inductions, where each aspect of the therapist's clinical function elicited suitable, *reactive* role-appropriate behaviour on the patient's behalf, were strongly characterizing features of the therapeutic interaction.

We can hence assert the eighth strand of the developing argument: therapists exercised not only an important authorial privilege, in leading, amplifying and co-constructing patients' therapeutic narratives, but *they also exercised an important interpellative function by virtue of which they were able to irrefutably position patients in relation to a given set of therapeutic meanings, emotions and roles. Role-induction appeared to be the most basic of these various forms of interpellation*.

Constructing ailments

The interpellative capacity with which therapists were able to use words, emotions and roles within psychotherapy seemed most apparent in their attempts to probe for, and then solidify, psychological problems *within* patients. A brief example illustrates how the therapist is able to place the attribution of emotional disturbance within the patient's narrative. Here the probe for emotions capitalized on current feelings exhibited by the patient, and in fact, the apparent anger of the resistant patient was very nearly transformed into the emerging surface of a larger presenting problem:

Pt. Dr … sent me here for these headaches. He thinks it might be mental. I don't think it was necessary for me to come.

Th. Do you believe it's mental?

Pt. Good Lord, No! I think I need something that will ease this pain, I've been told a million different things of what's wrong.

Th. Perhaps you are right. It may be entirely physical. What examinations have you had?

Pt. *(Patient details the many consultations he has had, maintaining his position that his problem is physiological).*

Th. Then it perhaps made you angry to come here?

Pt. I was angry. Not now though. Do you think you can help this headache?

Th. I'm not sure; but if you tell me about the trouble from the

beginning, I might be able to help you with any emotional factors that can stir up a headache.

Pt. How can that do it? I know I have been emotional about it. (Wolberg, 1977, p. 398)

Noteworthy here is the way in which the therapist has asserted an emotional problem, if not as the fundamental complaint, then as undeniably attached to or as having intrinsically surrounded the presenting complaint. Despite the fact that there is sometimes quite plain resistance to these emotional attributions, via doubt and refutation, the patient nonetheless ends up 'picking up' the threads of language placed within the therapeutic narrative by the therapist, absorbing it into his self-explanations.

Important in the following extract is the distinction between physical and emotional symptoms which ultimately appears to be collapsed by the therapist's interpellative probing of emotional forms of disturbance. Interesting also is the number of times that the patient refutes the therapist's emotional attributions, and the struggle that occurs over such an attribution of feelings and emotional difficulties. Indeed, these appeared to be key stakes in the development of the therapeutic narrative, and in the struggle for authorship which infrequently accompanied its development.

Pt. But how can stomach trouble be caused by the mind?

Th. The brain is connected to every organ in the body, and when a person is disturbed, it is understandable that the disturbance or worry or conflict can get into every organ of the body …

Pt. But there's nothing wrong with my mind. I'm not worried about anything except this pain and how to get rid of it.

Th. Perhaps that's right. As a matter of fact you may have something really wrong with your stomach …

Pt. Do *you* think there is nothing wrong with my stomach?

Th. There must be something wrong; otherwise you wouldn't have any pain. The question is whether the cause of the pain is emotional, or organic, or both. Frankly I don't know which it is … But from your account nothing organic has been found. And you've had good doctors. Dr … is a good doctor … and he sent you to me, which shows he feels there is at least the possibility of an emotional factor.

Pt. But what could it be, if it isn't my stomach?

Th. You mean what would the emotional factors be if your stomach trouble was not organic?

Pt. Yes.

Th. That's why you where referred to me. Perhaps we might be able to find out. You know emotional trouble can give you a bigger bellyache than physical trouble … Apparently you can't accept this fact as applying to you. Maybe you think it is disgraceful to have emotional problems?

Pt. … Well, maybe it's so, but I don't, can't see, how. Wouldn't I know if there was something wrong with my mind …?

Th. With your emotions you mean? …

Pt. … do you think *you* can help me?

Th. If you have an emotional problem that is causing this trouble, yes … if you really want to be helped … but you are still not convinced. Why don't you think things over, and, if you'd like to give this a try—with an open mind I mean—call me and we'll get started.

Pt. I get pain over here. (*points to his abdomen*) … it drives me practically out of my mind.

Th. You know, a person with even a real organic problem … can get very upset. And his emotional tension can … stir up trouble … So you see, emotional trouble … can upset your stomach. (Wolberg, 1977, pp. 466–467)

Probing of this sort, whilst clinically valid both as ways of surfacing material that the patient would otherwise avoid, and as means of approaching more pressing problems than those first identified by the patient, creates an interpellative 'net' of emotional ailments. As suggested earlier, propositions of emotionality lack comparative frames of reference, just as they lack accurate measures of degree. In this way we may assert that *therapists have what may be considered 'an interpellative net of emotional ailments', a powerful latitude in identifying and fixing the strength and appropriateness of feelings within patients, and in ascertaining the 'pathology' within such feelings*.

Declarative powers

The constructive and interpellatist capacities of the psychotherapist were substantiated by a more crude instructive or *declarative* power which was difficult at first to ascertain precisely because its functioning was so implicit. Attempting to generate an explanation for why there was such a (relative) lack of resistance amongst patients to therapists' interpretations, directions and suggestions within the psychotherapy, the researcher turned to examine exactly how therapists *themselves* bolstered and validated their contributions to the therapeutic narrative. The answer, as provided by therapists themselves, proved to be fairly easily forthcoming:

Th. … as we begin to talk about your problems, things will become more obvious to me than to you. This is because I can be more objective than you. You live too close to your problems to be objective about them. Second, I'm trained to do psychotherapy and can see the problems better. (Wolberg, 1977, p. 1050)

Basically, therapists' contributions to the therapy were authoritative, loaded with the weight of a qualified and professional sense of 'psychological expertise', factors which they themselves did not typically seek to minimize. The contributions of therapists hence functioned, particularly from the perspective of the patient hopeful for a cure, in an *definitive or prescriptive* rather than a descriptive or hypothetical manner. In this way, even the slightest indications and suggestions of the therapist carried an implicit instructive force, despite frequently being voiced in the indefinite sense:

Pt. … I'm being forced to see those old friends … whom I don't want to see. What can I do?

Th. It may be that you have to take a stand with some of your friends. (Wolberg, 1977, p. 1053)

Never unconditionally direct, these guarded therapeutic suggestions never took the form of

advice, or prescription, whilst implicitly managing to fulfil this function nevertheless. Indeed, this form of instructing was overwhelmingly managed by implication: not so much by *what* was said, but by *how* it was said. The following extract contains the therapist's notes on tone and inflection:

> *Pt.* … it all seems so hopeless.
>
> *Th.* Particularly when you give, give, give, and nothing happens. *[implying indirectly that she gives materiall to make up for a lack of substance within herself]*
>
> *Pt.* I always enjoy doing things for people.
>
> *Th.* I guess you do. *(pause) [this is said a little ironically]*
>
> *Pt.* Why, is that wrong …? *[the patient picks up the irony of my tone]*
>
> *Th.* Why should it be wrong?
>
> *Pt.* I don't know.
>
> *Th.* Let me ask you this, do *you* enjoy having people do things for *you*? (Wolberg, 1977, p. 1062)

Evidence of the instructive force of therapists' contributions was particularly noticeable in comments made by patients:

> *Pt.* Yes, doctor, I see what you mean. (Wolberg, 1977, p. 1063)
>
> *Pt.* Yes, I can see. I can see how what you've told me is true. (Wolberg, 1977, p. 1088)
>
> *Pt.* Yes, and then I felt, well Dr. Wolberg says no, that sort of thing is just poison for me, and why do I want anything that isn't good. (Wolberg, 1977, p. 1089)

The instructive power of the therapist is clearly evoked in the following passage (the patient's part of the dialogue has been omitted to foreground the therapist's instructive role):

> *(Speaking of the patient's always giving, never receiving pattern of interaction)*
>
> *Th.* You really feel you haven't been on the receiving end? You've been on the giving end … […] To be on the receiving end, you'll have to think enough of yourself so that you feel you can deserve receiving … […] … The best way is through good relations with people. Perhaps you minimize a lot of things that you have about yourself … […] … Well it isn't too late to change … […] … It's important for you to be discriminating, even if you wait … […] … Another experience that tears you down will be very hard to bear … You've already gone through enough, except for that one interlude in your life … […] … If it comes again you have to be ready for it. You can't expect to be ready if you have a bad opinion of yourself. If you correct the bad opinion of yourself, when someone worthy comes along, you'll be able to accept the situation … […] … There is one thing you may have to watch for when you meet a worthwhile person. In the face of this man's apparent good qualities, you may say to yourself, 'Well, gosh, he'll never see anything in *me*. Why should I get myself messed up over him? If he sees something in me, it's because he just wants sex, or because he wants to take advantage of me, or something like that; it isn't likely that he respects me for myself.' And after that, you won't give him a chance; you'll just run like a deer. Now you've got to build up this estimate of yourself, if things are to be different.

> We have a fairly good idea of the origin of this bad estimate of yourself in your early upbringing. But this has produced in you an extremely insidious situation in which you keep on despising yourself, in which you feel you have no inherent qualifies, in which you feel that you can only be loved for what you can do for people, and not for yourself. Now these patterns keep messing you all up … (Wolberg, 1977, p. 1080)

In the lengthy extract given above, the therapist 'tells how it is', provides a summarizing and definitive assessment of the patient's typical patterns of interaction, rooted in the patient's early history. This is more than a description or a general likeness, it is *the* conclusive, clinical distillation of the patient's problem. By virtue of their expertise and qualifications, their clinical experience and knowledge, the offerings of the psychotherapist, whether interpretations, hypotheses, tacit suggestions or confrontations, carried powerful and prescriptive truth-claims. Quite simply put, the therapist had a privileged vantage on the truth of the patient's psychological life; they were in possession of a more accurate and effective psychological knowledge of patients than patients themselves were. Here then we might state the 10th strand of this argument: *there is, practically speaking, no higher authority within psychotherapy on the psychological life (and prospective psychopathology) of the patient than the psychotherapist themselves, whose therapeutic contributions typically function, on the part of the patient, as definitive and prescriptive rather than descriptive or hypothetical.* Lastly, and as way of pulling together the critical impetus of these collected arguments, *the 'problem-centric' nature of the process, along with the tactical and technical abilities afforded the therapist in order to 'discover' psychopathology, ultimately lacked a balancing set of controls, or a means of effective form of opposition, a fact plainly advanced in the assertion that there was, practically speaking, no higher authority within the psychotherapy on the psychological life (and prospective psychopathology) of the patient than the psychotherapist themselves.*

Conclusion: a 'psychotherapeutic technology' and the problems it poses

One might hence surmise, on the basis of the study discussed above, that psychotherapy is a highly technological process which puts a variety of applied skills, techniques, strategies, and specialized forms of knowledge and language at the disposal of the psychotherapist. In fact in many ways it seems that there are alternative grids of analysis to that of *curative effect*, through which one might gauge the workings of 'therapeutic efficacy'. Indeed, on this basis, one may affirm, with some confidence, the notion, asserted by Foucault (1977) and Rose (1991, 1995) that psychotherapeutic intervention may be likened to a *technology*. That is, a technology in the sense (as suggested above) *of a set of applied skills, techniques, strategies, and specialized forms of knowledge and language used conjointly as part of a systematic goal of control.* In this way one might re-code the workings and efficacy of psychotherapy not with reference to a vocabulary of therapeutic healing, or to a register of amelioration and benefit, but instead with reference to a powerful therapeutic *technology* of attempted change, control and influence.

What does this new way of looking at psychotherapeutic intervention afford us? Well, it emphasizes the authority, the constructive, interpellative and authorial privileges that the experienced psychotherapist has at their disposal; it emphasizes the extent of *the power* and of *the vast technical capability* therapists maintain within the clinical realm. This in its own right does not make for much of an argument about how psychotherapy necessarily produces psychopathology. What it does make for is a formidable demonstration of the technical means that would enable psychotherapists to discursively produce psychopathology should they chose to do so. This itself seems a less than a decimating—or even original—argument,

in that it seems, basically, merely to defer to the well-worn sentiment *that psychotherapists do of course have a great deal of power, and that is exactly why they should at all times aim to formulate their practice in only the most carefully considered and ethical forms of intervention*. The argument advanced here says more than this, however. It suggests that we have underestimated (or actively downplayed) the true volume of this power, and in so doing have mistakenly put forward the belief that ethical therapeutic practice itself, the self-moderation of the concerned and cautious therapist itself, will be enough to guard against its active generation of psychopathology. Even particularly astute, self-reflexive, self-critical and ethical psychotherapists themselves are not basis enough to halt the pathogenic qualities of psychotherapy (although consciousness-raising around this quality is laudable). Why are therapists themselves not enough? Because, if one takes the findings of this research seriously, one understands that a *psychotherapeutic technology has this pathogenic, problem-centred, problem-seeking faculty indelibly written into its most rudimentary designs, its most basic structures*. Effectively utilized psychotherapeutic technology cannot discursively locate and substantiate psychopathology; that is, its 'brief', its mandate, *its whole underlying motivation and impetus*. The most meticulous, the most thorough, the most ethically scrupulous therapist in the world cannot effectively guard against this pathogenic quality of psychotherapy, precisely because this is in fact *exactly* the function, however variously or elaborated articulated, of psychotherapy in the first place.

If there were to be reasonable guards against this pathogenic function of psychotherapy it would have to be those *being treated by it*. (Indeed, intuitively it makes for a weak claim of equity to suggest that it is only necessary for those who 'operate' instruments of power to moderate them. A reasonable sense of equity can only be insured, or so it would seem, if those being 'operated upon' by such instruments do not have recourse to effective means of resistance.) This, however, is unlikely—if not in fact impossible—and for a number of reasons. For a start, patients of psychotherapy abide by a discourse of therapeutic healing, the above mentioned register of amelioration and benefit, rather than a discourse of therapeutic technology, or a register of attempted change, control and influence. (One assumes such patients would not be in therapy otherwise.) Secondly—and here we are reminded of a number of assertions made in the foregoing analysis—the technical and tactical abilities afforded therapists to 'discover' psychopathology appear to lack an adequate basis of refutation from which patients may contest or resist such productive efforts.

If then it is both the case that psychotherapists have a dazzling array of instruments and resources with which to 'call psychopathology into being', and that this productive capacity is fundamentally inequitable in the sense that it lacks an adequate set of controls and balances, then we have a real problem on our hands. To this argument we may add the notion that psychopathology is the *raison d'etre* of psychotherapy, its prime object and its means of sustenance. And this is a claim which seems particularly difficult to dismiss, that psychopathology is in fact exactly that which acts as *the* motivating rationale which both *validates* and *warrants* psychotherapy, that which enables and extends the ongoing perpetuation of its practice. If we are to believe those critics, like Isack and Hook (1996) and Parker (1999), who claim that psychotherapy entails a staunch and active economic imperative to uncover and substantiate psychopathology, then this combination of technological prowess with such a psychopathology-seeking imperative poses a substantial ethical dilemma. If it is the case that psychotherapy, like the individual psychotherapist, has enormous investments of career and identity in this entity, then it may well be, as suggested earlier by Isack and Hook (1996), that there is never a therapeutic interaction without an attendant gravity, or even in fact *compulsion*, to unearth, substantiate and treat psychopathology.

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Hence, rather than a *precondition* of psychotherapy, psychopathology may, in a very substantial way, be thought of as *a function of psychotherapy*, an outcome of a psychotherapeutic interchange designed and structured to engender psychopathology, to relentlessly seek it out, to discursively substantiate it and its various approximating forms. If it is the case that a great deal of the formidable technical prowess of the experienced psychotherapist is weighted towards the detection, substantiation and 'foreclosure' of psychopathology, then psychotherapy comes dangerously close to being an iatrogenic process. (Again, intuitively, one feels that a huge latitude of power, taken alongside the lack of any significant threat of appraisal, cannot but lead to abuses of power.) Further yet, if it is the case that the gravity to discover psychopathology within psychotherapy is, at times, so overbearingly strong that the therapist cannot fail *but* to uncover some suitable 'problem in living', some suitable 'working focus' for the therapy, then psychotherapy is *a constitutively iatrogenic form of treatment*. And this is the ethical conundrum: if psychotherapy is iatrogenic in either a strongly potential or a constitutive sense, then how can it continue to be thought of as ethically viable?

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Résumé *L'objectif de ce papier est construire une discussion par induction persuasive comment la psychothérapie peut être dite pour produire psychopathology discursivement. Focussing attentivement sur les mécanismes techniques de ce qui est appelé finalement un 'technology' psychothérapeutique—c'est, un ensemble de compétences cliniques appliquées, techniques, stratégies, et formes spécialisées de connaissance et langue utilisé par le psychothérapeute—l'auteur mène une analyse de la théorie fondée empirique d'une série séquentielle de sessions de la psychothérapie du psychodynamic, a mené et a publié par un bien—a respecté le praticien. Sur cette base, l'auteur fait une série de demandes qui centrent autour de l'interpellative, rôle—par induction et les prérogatives de l'authorial se sont offertes des thérapeutes par le processus thérapeutique, prérogatives qui leur ont fourni la latitude constructive assez pour produire psychopathology dans les comptes de malades d'eux-mêmes discursivement. La*

'pathogenic' nature de ce processus, avec les capacités tactiques et techniques s'offertes des thérapeutes dans ordre à 'discover' psychopathology en outre un ensemble hésitant de contrôles a manqué. Ce mélange d'une telle technologie puissante d'intervention, sans un raisonnable (ou malade-centré) ensemble de comptoirs et moyens des balances que la psychothérapie vient près d'être un iatrogenic du constitutively dangereusement formez de traitement.

Zusammenfassung *Das Objektiv dieses Papieres sollte ein überzeugendes induktives Argument als dazu bauen, wie Psychotherapie gesagt werden könnte, um psychopathology weitschweifig zu produzieren. Focussing eng auf dem technischen workings von dem, was schließlich genannt wird, ein' psychotherapeutischer technology'—das heißt, ein Satz von angewandten klinischen Fähigkeiten, Techniken, Strategien, und spezialisierten Formen von Wissen und Sprache, der vom Psychotherapeuten genutzt wird,—der Autor flirt eine empirische gelaufene auf Grund Theorie-Analyse von einer sequentiellen Folge von psychodynamic-Psychotherapie-Sitzungen durch, führte durch und veröffentlichte durch ein nun-respektierte Praktiker. Auf dieser Basis macht der Autor eine Folge von Behauptungen, die sich um den interpellative konzentrieren, Rolle-induktiv und authorial-Vorrechte leisteten Therapeuten durch den therapeutischen Prozeß, Vorrechte, die sie mit konstruktiver Breite genug versorgten, um psychopathology weitschweifig innerhalb Patienten Konten von sich zu erzeugen. Die 'pathogenic' Natur dieses Prozesses, zusammen mit den taktischen und technischen Fähigkeiten fehlte, die Therapeuten weiterhin in Reihenfolge zu 'discover' psychopathology geleistet werden, ein ausgleichender Satz von Kontrollen. Diese Mischung von so eine mächtiger Technologie von Eingriff, ohne ein vernünftig (oder geduldig-konzentrierte) Satz von Schaltern und Gleichgewichten bedeutet, daß Psychotherapie gefährlich in der Nähe vom Sein kommt, ein konstitutiv iatrogenic-Form von Behandlung.*