

## **EXPLORING THE CONTRIBUTION OF SUBJECT POSITIONING TO STUDYING THERAPY AS A DIALOGICAL ENTERPRISE**

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**ABSTRACT.** Recent social constructionist and dialogical approaches to psychotherapy have pointed to the usefulness of attending to language, meaning and dialogue in conceptualising client difficulties, the process of therapy and therapeutic change. This paper explores the contribution of the analytic concept of subject positioning in examining therapy as a dialogical enterprise. More specifically, it is suggested that the notion of subject positioning offers the potential of studying therapy as an interaction, attending to the active role of therapists, and taking into account the powerful role of context in people's sense of self and in the course of therapy. This wider focus is in line with the constructionist trends in the dialogical self tradition and can enrich current analyses of therapy process from a dialogical perspective. The arguments put forward are discussed through reference to existing literature and to a brief analysis of a therapy session extract.

Over the last two decades there has been a significant trend in psychotherapy theory, practice and research that draws upon, and contributes to, the flourishing narrative, dialogical, discursive, constructivist and social constructionist approaches in the human sciences (e.g., Angus & McLeod, 2004; McLeod, 1997; McNamee & Gergen, 1992). These developments seem to have powerfully affected psychotherapy theory and practice from different paradigms, often blurring traditional boundaries between theoretical orientations. For example, there are several authors that propose reconceptualising the assumptions that underlie the theory and specific techniques in psychodynamic therapy (Bromberg, 2004; Spence, 1982), cognitive (Neimeyer & Mahoney, 1995), process experiential/ existential (e.g. Angus & McLeod, 2004; Whelton & Greenberg, 2004) and systemic therapies (Anderson & Goolishian, 1988), in terms of narrative, dialogue and discourse. In addition to these elaborations of more traditional orientations to therapy, several approaches to therapy explicitly associated with the 'turn to language' have been articulated, such as narrative therapy (White & Epston, 1990), dialogical self (Hermans & Dimaggio, 2004), and Open Dialogue (Seikkula & Arnkil, 2006).

The various dialogical and narrative perspectives on therapy constitute a diverse field that includes notions developed in different traditions, with differing applications,

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and often relying on different epistemologies. Notwithstanding their differences, a common thread in these approaches to therapy is the focus on meaning, which is considered to be constructive of human experience and constructed within interaction and within specific sociocultural contexts. Therapy in these approaches is conceptualised as primarily a semantic process, i.e. a process of meaning construction, whereby the clients come to gradually reconstruct their life narratives in ways that are increasingly complex, evocative, inclusive, polyphonic and flexible; moreover, this shift is assumed to take place through the process of collaborative dialogue. In the same framework, psychological problems are approached as interactional and discursive phenomena that are created, maintained and dissolved in and through language and social interaction (Anderson & Goolishian, 1988; McNamee & Gergen, 1992). Broadly speaking, this literature tends to expand the focus from individual psychology to the social, political and cultural conditions that produce mental distress; some versions also aim to critically examine the systems of meaning and associated institutions that are available for individuals to make sense of their experience (Fee, 2000). In addition, these approaches attempt to overcome the dualist distinctions between nature and culture and between the individual and the social levels of understanding mental distress (Blackman, 2005) and, as such, aim to explore the links between experience, meaning and culture.

In this paper I describe the analytic concept of subject positioning, discuss its relevance to a dialogical conceptualisation of therapy and focus on its usefulness as an analytic tool in examining therapy session transcripts in terms of dialogical processes. Subject positioning has been mainly associated with discourse analytic research, although in recent years there has been an interest in the concept in the context of dialogical self approaches (e.g. Hermans, 2004; Raggatt, 2007) as well as in approaches that combine psychoanalysis and discourse analysis (e.g., Hollway & Jefferson, 2000; Frosh, Phoenix, & Pattman, 2003).

In order to locate the arguments developed in this paper in context, I outline briefly the theoretical shifts that have been proposed in relation to the notion of selfhood in the narrative, discursive and dialogical approaches to therapy. Traditional psychological accounts broadly utilise the notion of personality, considered to be an identifiable, stable and internally consistent entity that initiates behaviour, and generally assume that a person is an individual, unified, stable and self-contained entity. Over the last decades these approaches have been powerfully challenged on several grounds, such as being naïve realist and essentialist, and for providing individualising and ethically problematic accounts (Shotter & Gergen, 1989). Among the alternative accounts of personhood that have been developed, the theory of the dialogical self (Hermans, 2002) and positioning theory (Harré & van Langenhove, 1999) have sparked important developments in therapy theory, practice and research, as outlined below.

### **Dialogical self theory psychotherapy**

Dialogical self theory draws upon narrative and discursive accounts of subjectivity and, drawing from Bakhtin (1929/ 1973), suggests that the self resembles a polyphonic novel, containing a multitude of internalized voices engaged in dialogue. The notion of the dialogical self has offered a conceptual tool for developments in several areas of psychology and the social sciences, as well as psychotherapy (Hermans & Dimaggio, 2004). These diverse strands of development, however, have resulted in a relative lack of coherence regarding the meaning of key terms in the theory –including that of the dialogical self (Raggatt, 2007). In the majority of the literature, the dialogical self has been conceptualised in terms of *a conversation between voiced positions*. This internal dialogue is thought to comprise of ‘oppositions, agreements, disagreements, contradictions, negotiations and integrations’ (Hermans, 2002: 148) and so multiplicity, negotiation and dynamic conflict are considered intrinsic qualities of a well-functioning self. Importantly, coherence is considered to arise out of dialogical relationships, rather than to reflect the dominance of a singular voice over others. The second main way in which the dialogical self has been conceptualised is as *a society of mind* (Hermans, 2002, 2004), a metaphor that invokes the idea of social positioning, that is the assumption that self-positions are historically and culturally located and that societal and cultural norms are reflected in the internal conversations and affect the relative dominance of different self-positions (Raggatt, 2007).

In terms of therapy research, the majority of relevant studies rely on the assumption that the dialogical self comprises of a set of voiced positions in conversation, and examine the content and characteristics of the person’s position repertoire and the dialogical relationships between them. The analysis aims to understand the dynamics of positioning between voices and the researcher typically conducts a content analysis of the clients’ narratives. Hermans (2004) proposes examining (a) the content of the client’s position repertoire (i.e. what voices the person has and what they have to say), (b) the organization of the position repertoire, i.e. the hierarchy or degree of integration of the various I-positions, their accessibility, the flexibility to move between positions and the affective variety between positions, and (c) the relationship between positions, mainly in terms of the potential for dissociation from -or disowning of- certain positions (Hermans, 2004). The main studies of therapy that have been conducted in this framework are briefly presented below.

Lysaker & Lysaker in a series of publications (see Lysaker & Lysaker, 2008) have cogently argued that schizophrenia entails severe dialogical disruption, which is associated with the alienation, sense of personal diminishment and loss of vitality that often characterises the personal experience of people diagnosed with schizophrenia. They propose a form of analysis that focuses on the identity and the type of the characters and self-positions in the client’s narrative, as well as on the interactions between them. Drawing on a number of studies they have conducted, Lysaker and

Lysaker propose a categorization system for the various forms that dialogical disruption can take in schizophrenia: (a) the collapse of narrative, reflected in barren self-organisations, that leave the person with a diminished sense of agency and temporality, (b) cacophonous internal conversations that take place with no organising structure and lack coherence, and (c) rigid and monological internal conversations, dominated by a singular, tyrannical voice (2008). These studies provide a theoretically sound and clinically useful description of what goes wrong in schizophrenia in dialogical terms, as well as a way of conceptualizing and studying change in therapy. In a similar vein, Dimaggio, Salvatore, Azzara & Catania (2003) examined changes in the principal characters populating one client's written narrative, the dialogical relationships between them and the discursive construction of a meta-position. Although this study did not analyse actual session transcripts it illustrates very clearly the dialogical nature of the self as well as the shifts observed in self-positions through therapy. Another set of studies propose a typology of 'ineffective narratives' according to various features, such as the level of coherence in the story's structure, its emotional salience, and linguistic evidence for self-observation and self-reflection (e.g. Dimaggio & Semerari, 2001; Gonçalves & Machado, 2000). These papers do not study therapy per se but propose systems of describing various forms of 'pathology' in dialogical terms, which may in turn be used to track changes in therapy. In summary, there exists a growing body of research that examines therapy using the notion of voice and generally suggests that the process of change in therapy can be evidenced in the development of richer dialogues between voices in the client's narrative, in a decrease in disorganization or dissociation, and in the development of a reflexive meta-position.

As may be evidenced from the above, the notion of voice provides a systematic and clinically relevant way of approaching therapy as dialogical enterprise that can be fairly easily assimilated within several different schools of therapy. On the other hand, it seems that the majority of the dialogical self literature on therapy to date has approached voices as primarily personal constructions and has tended to sidestep the interactional and socio-discursive aspect of positioning. Exceptions to this trend are Dialogical Sequence Analysis (Leiman, 2004) and Dialogical Investigations of Happenings of Change (Seikkula, Laitila, & Rober, 2011) that provide systematic ways of analysing dialogue in therapy; however, published studies to date have focused mostly on illustrating the system, rather than examining therapy process per se.

### **Subject positioning in researching therapy**

In social constructionist accounts, the notion of personality has generally been substituted by that of subjectivity, a notion that evokes the set of processes by which a subject or self is constituted (Henriques, Hollway, Urwin, Venn, & Walkerdine, 1998; Wetherell, 2008). Personal experience and one's sense of self are approached as discursive accomplishments, jointly constructed in specific interactions and within the

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broader framework of culturally available systems of meaning (Avdi & Georgaca, 2009). In these accounts, subjectivity is considered as complex, fluid, distributed and fragmented (Blackman, Cromby & Hook, 2008) and is often approached through the notion of subject positioning.

Positioning theory, although not a unified theory of selfhood, provides a set of conceptual tools which allow us to explore the relationship between discourse and subjectivity (Davies & Harré, 1990; Harré & van Langenhove, 1991) and to investigate the intimate interlinking between culture, social processes and the self. More specifically, subject positioning refers both to how one is positioned in particular interactions, i.e. the position from which one speaks and the position in which one places the person they address, and to how one is positioned through particular discourses, i.e. to the types of subject made available through the deployment of different discourses and their associated practices (Willig, 2008).

Positioning is intimately linked to discourse, as discourses entail an array of subject positions that people take up when they talk, often irrespective of their intentions and outside of awareness, and these positions influence the course of interactions as well as people's sense of self (Parker, 1992). For example, when a therapist meets a client, the way each participant interacts and experiences him or herself in the interaction is influenced not only by their individual biographies, but is also powerfully shaped by their respective, institutionally defined positions. Therapy as a discourse and institution relies on the complementary primary positions of 'therapist' and 'client' that function to prescribe how each participant is expected to act and talk (Guilfoyle, 2006). These positions are primary in the sense that they operate irrespective of the therapist's intentions or therapeutic orientation. The therapist subject position is imbued with expertise, authority, knowledge and turn-shaping influence, whereas the client's position assumes that he or she is knowable (i.e. he or his problem can be understood by therapy's system of knowledge), malleable (i.e. hoping for and ready for change) and deferring (a client's understanding of events is not-yet-final and open to interpretation) (Guilfoyle, 2005, 2006). Moreover, these positions are automatically assumed by the participants, independently of each participant's personal biographical path, although in interaction with it. Therefore, these positions exert a powerful influence on the unfolding interaction, irrespective of the participants' intentions; for example, the inherent asymmetry between 'therapist' and 'client' with regards to expertise, knowledge and authority holds strong, despite many therapists' genuine attempts to create more egalitarian and collaborative practice.

In other words, discourses naturalize their knowledge claims, so that these claims seem natural, inevitable and taken for granted (Willig, 2008). In this way, hegemonic discourses exert power, functioning to preserve, legitimate and naturalize the interests of powerful social groups (Wetherell & Edley, 1999) and have important effects on how people see the world and experience themselves (Parker, 2005). The

main thrust of this argument is that self descriptions, although may be experienced as authentic self-productions, actually reflect a 'selection from the panoply of selves already available to be donned' (Wetherell & Edley, 1999: 343), and that this process, more often than not, remains unrecognized; it is in this sense that it lies outside of awareness. An example of a powerful discourse regarding selfhood in contemporary western society is 'self-contained individualism' (Sampson, 1993). This self embodies two principal features; the first is associated with the notions of self-determination, personal agency and self-definition, and the second with the notion that clear boundaries between self and others are necessary prerequisites for mature and healthy psychological functioning. These constructions are promoted as ideal by several contemporary institutions, including psychotherapy (Cushman, 1990; Guilfoyle, 2002), and are generally accepted as part of common-sense knowledge of what it means to be 'person'; it is in this sense that such constructions shape how people in western cultures interact with one another and see themselves. Given the above, it has been argued that analysing discourse can show how powerful images of the self and the world circulate in society and such analyses may open ways of questioning and possibly resisting taken for granted images (Parker, 2005; Willig, 1999). I would like to argue that the critical engagement with one's system of values and knowledge that may result from researching processes of positioning in relation to psychotherapy can promote therapist reflexivity and client empowerment, as it may help clients to recognise and question restraining and pathologising discourses.

As discussed above, subject positioning locates the person in sets of meanings and social relations that regulate and constitute what can be thought, said and done, and exerting powerful effects on how the person sees him- or herself (Willig, 2008). In other words, the notion of positioning emphasises the location of the person in discourse and within a moral order (Harré & van Langenhove, 1991). As such, subject positions are hierarchically organised, with some being culturally preferred or dominant, whereas others being stigmatized or marginalized. For example, Madill & Doherty (1994) and Madill & Barkham (1997) explored the client's positioning in a therapy with a woman presenting with depression. They argued that the client, drawing upon dominant discourses regarding ideal femininity, presents her account in terms of obligations to others, while the therapist, drawing upon a western, 'masculine' individualist account, constructs her as a passive recipient of other people's wishes and so inherently 'problematic'. In the second study, the subject positions the client employs for herself and her mother were explored; these include the 'dutiful daughter', the 'bad mother' and the 'damaged child', and the effects of these constructions on the client's experience were explored. The therapist was shown to discursively construct an account of the client's life, which is morally defensible within her own frame; more specifically, the placement of the client's mother into care is gradually constructed as justifiable and as necessary to alleviate the client's depression. This reconstructed narrative allows the

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client to maintain the 'dutiful daughter' position, whilst also feeling justified in placing her mother into care. These studies provide an example of how positioning is interactionally negotiated, and how discourses can be strongly implicated in personal distress.

Furthermore, some subject positions are transient and fleeting, whereas others become habitual ways of being, providing a sense of continuity over time and coherence across situations (Willig, 2008). This is a much contested point, as discursive theorising cannot readily account for the observation that people tend to inhabit particular subject positions, often with great tenacity or indeed rigidity, in contrast to the fluid and fleeting nature of selfhood assumed in positioning accounts (Henriques et al., 1998). The notion of 'investment' has been proposed to describe the valued and emotionally charged self-presentations that individuals seem to hold onto (Henriques et al., 1998; Wetherell & Edley, 1999). In recent years, several authors have drawn upon psychological accounts, and notably psychoanalysis, in an attempt to explore individuals' investment in specific positions. It has been argued that psychoanalysis –in terms both of theory and methodology- can enhance our understanding of the complexity of the subject positions that a person occupies, and of the psychological processes that underlie an individual's investment in any particular position (Frosh & Emerson, 2005). Moreover, the associated notion of 'complex subjectivity' assumes the existence of individual motivation and desire, mediated through cultural forms yet not reducible to these, and as such can help address the thorny issue of change in positioning and of resistance to the power of discourse (Georgaca, 2005). Several psychological notions have been used –such as unconscious conflict, desire, fantasy, emotional investment and defence- in a growing number of publications that combine psychoanalysis with discursive analysis in exploring subjectivity (e.g. Frosh et al., 2003; Hollway & Jefferson, 2000; Wetherell & Edley, 1999), although these are not without their critics (Frosh & Emerson, 2005; Gavey, 2002; Søndergaard, 2002). Akin to psychotherapy itself, these studies pay close attention to biographical details and to emotional subtexts, in order to generate a plausible analysis regarding the agentic struggles of individual subjects and their resulting investment in specific subject positions (Frosh et al., 2003). Focusing on personal positioning, several of these studies share many respects with studies that examine the client's voices and position repertoire from the viewpoint of dialogical self, although there is scant cross-referencing between these two research trends.

An important dimension related to the notion of subject positioning is that it is considered to be interactionally constructed. In practice this means that, when analysing a particular speech exchange, the researcher attempts to understand the subject positions the participants occupy both in the specific context of the particular interaction and within a wider sociocultural context with its associated systems of values and ideology.

In sum, it is argued that positioning is a ubiquitous process, closely linked to discourse, that constitutes an integral part in the construction of selfhood. As an analytic

tool, subject positioning expands the focus from the personal level to interaction and social processes. I would argue that this makes subject positioning particularly useful for therapy research, given that therapy involves a conversation between -at least- two people, takes place in a socio-cultural context and necessarily implicates power and resistance. I will briefly elaborate on these points and then present a brief example of analysis.

The first issue that points to the usefulness of utilising the analytic tool of subject positioning to study therapy relates to the fact that therapy is a conversation; therapy research from a dialogical perspective should therefore study therapeutic interaction rather than focus exclusively on the client's talk. Examining the interaction - by studying how language is used by the participants, how meanings are negotiated, the complex matrix of positions that the participants take vis-a-vis each other and the issues under negotiation, as well as the effects these processes have on the unfolding interaction- also highlights how therapy gets done in practice, helping to explore the active role of therapists, thus potentially becoming a useful tool in training and supervision that promotes clinician reflexivity (e.g., Avdi & Georgaca, 2007).

The second issue relates to the fact that therapy takes place in a cultural context. The notion of subject positioning examines the effects of culturally available systems of meaning, and their associated social institutions, on the actual interaction. This approach widens the lens through which therapy is studied and looks beyond the specific interaction to the way the wider context shapes its course. The point of interest here is how the client's position repertoire is affected by the wider cultural context both internally (i.e. in the hierarchy of their position repertoire) and in the actual therapist-client interaction, by allowing certain things to be talked about, whilst precluding others. Several subject positions associated with dominant discourses have been explored in relation to psychotherapy, such as ideals regarding family relations, gender and agency (see Avdi & Georgaca, 2007).

The final issue that points to the usefulness of adopting the notion of subject positioning to study therapy relates to power. Power is a complex and contested issue; here I take the view that power is not a static and unitary phenomenon, but rather a dynamic process that is present, and under negotiation, in every interaction (Burman, 1995). In the context of therapy, power can be broadly conceptualised as the capacity of the different participants to shape the unfolding talk and interaction (Guilfoyle, 2005); it is worth noting, that the issue of power has not been adequately addressed in dialogical approaches to therapy, which may reflect an assumption that dialogue somehow equates with the absence of power (Guilfoyle, 2006). The notion of subject positioning provides a useful analytic tool to conceptualize the therapeutic interaction in terms of power and resistance.

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Having outlined the main theoretical issues relating to positioning and its potential usefulness in studying dialogical processes in therapy, I now turn to a brief example of studying therapy in terms of subject positioning.

### **Studying therapy in terms of subject positioning: An example**

The extract comes from a family therapy that was studied as part of a larger project (Banani, 2008; Karatza, 2008; Karatza & Avdi, 2011) in collaboration with an outpatient service in Thessaloniki<sup>1</sup> that specializes in working with families in which a member has a diagnosis of psychosis. The family's consent was granted for this study and all potentially identifying information has been altered.

James is in his late twenties and the youngest of three children. He moved to the city in his early twenties to attend university, but he soon started to withdraw from his friends, eventually stopped attending university and, following the sudden death of his girlfriend, began to hear voices and have visions. He was diagnosed with schizophrenia and was subsequently hospitalised on several occasions; his symptoms persisted, despite being prescribed atypical antipsychotic medication. The therapy spanned over two years with a frequency of approximately one session per month and by the end James' symptoms had subsided significantly and his life was improved in terms of work and relationships.

The following extract is from the second year of therapy (session 14) in which James and Maria, his mother, took part; shortly before the extract presented, the reflecting team commented that James seems to always be calm, whereas his dreams and visions are always violent. They further suggested that he seems to have no angry feelings whatsoever and that this may be contributing to the content of his nightmares, as well as to the content of the voices he hears and the visions he experiences. The expression of anger is an important topic for this family and one that has been discussed on many occasions over the course of this therapy. In the early sessions both James and Maria insisted that they never get angry, that they are calm and placid people, and, importantly, radically different from James' father. It is worth noting that the parents lived separately since James' first breakdown, at which point Maria left their village and moved to the city in order to look after James. James' father, who did not attend any of the sessions, was reported to have fierce, angry outbursts and to have been repeatedly violent towards Maria, both verbally and physically. James' voices are mostly angry voices, often swearing at his father and encouraging James to harm him. One of the main issues discussed in previous sessions related to a hypothesis that the 'angry voices' that seemed to refuse to be silenced and that James experienced as symptoms of

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a condition, may reflect a disavowed internal voice. Attributing a new, non-pathological meaning to James' experience had been an important part of the therapy until this point.

### Extract <sup>2</sup>

- 1 Maria – I admire him because he is a strong child (...) but regarding his anger like the
- 2 girls said [members of the reflecting team] and I said (...) I want him to get angry (...)
- 3 James – [to the therapist] er, can I ask you something, as you are older? [Therapist –
- 4 mmm] and you are a doctor and know better (.) when you say I should get angr-, do you 5 advise me to get angry?
- 6 Therapist – no (.) only you can decide this (.) when you stop being afraid of your anger
- 7 (.) become able to tell people what you think
- 8 James – so (.) how can I get angry without getting into a fight? This is what I want to to
- 9 a-, to a-, to achieve
- 10 Therapist – you must discover a way, yes
- 11 James – so, so that I can say what I want [Therapist- yes] without getting into fights
- 12 Therapist- exactly
- 13 Maria –that's what he must do
- 14 James– I want to say something (.) I am not quick witted, I am not quick witted, my sister 15 is very quick witted
- 16 Maria – he is very shy (.) that's what it is
- 17 James – I am shy like (.) I haven't th (.) no I don't think beforehand (.) today I am not
- 18 quick witted like to be able to to (.) to answer on the spot (.) I must think before
- 19 answering (.) because I think of so many things in order to answer
- 20 Maria – can I say something?

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<sup>2</sup> The transcription notation used is as follows: (.) = short pause, [...] = extra-linguistic information or brief interjections by another speaker, / = simultaneous speech by two or more speakers, (...) = part of the dialogue not included

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- 21 James – do you see?  
22 Therapist – yes, I wouldn't like to say /  
23 James – I don't say whatever comes to mind so that nobody will listen to me /  
24 Therapist – that I can advise you what to do, I cannot (.) cannot do that and none  
of us  
25 can do that (.) what I can do and my colleagues can do is to tell you our opinion  
so that 26 you think /  
27 James – yes, it's your opinion I want /  
28 Therapist - about it /  
29 James - of course /  
30 Therapist - and then see what you will do  
31 James - if you had a similar problem, which I don't wish upon you (.) and which  
you  
32 don't have [Therapist: mmm] what would you do in my place?  
33 Therapist - I don't know  
34 James - you see?  
35 Therapist - I would need to have it  
36 James - you see?  
37 Therapist - I would need to have it  
38 James - you see? Ah, if you are not like someone /  
39 Therapist - of course, many people have the same problem perhaps not as big as  
yours (.) 40 eh (.) we all have it to some extent (.) many people have this  
problem  
41 James - of anger?  
42 Therapist – perhaps, yes, anger, like, others get angry and they immediately get  
a  
43 headache and they stop

From the perspective of personal positioning this extract could be read as an example of a shift towards increased polyphony in James' position repertoire and the emergence of a reflective voice. There is evidence that James can access with greater flexibility part of his experience that was previously rigidly disowned; that is he can begin to own and to explore the meaning of an angry part of himself, an angry voice. Moreover, he explores, in a reflective manner, the possibility that an 'angry voice' may exist alongside the more familiar 'calm voice', which represents an important aspect of

himself that doesn't like fighting and is clearly different to his father. This reflection points to the emergence of a reflexive voice.

Next, I give a brief example of how one could approach the same extract using the notion of positioning. The analysis presented is necessarily limited and aims to highlight some of the issues that can be explored, when analysing therapy through the notion of positioning as an interactional and discursive phenomenon. In the beginning, Maria positions James as 'strong' and at the same time 'a child', a positioning which does not represent him as weak or needy, yet infantilises him. This positioning probably reflects the particular family's dynamics, where James lives with and is cared for by his mother in many important practical ways, and as such, arguably, occupies a child's role. In addition, this positioning is possibly also linked to James' status as a psychiatric patient, a position that is often associated with reduced agency. It has been argued that some institutionally sanctioned positions, such as that of a psychiatric patient, tend to dominate the person's identity and to strip the person of agency (Harper, 1995). James is clearly the client, and as such his behaviour and identity become an issue for others to comment on and advise about. At the same time, Maria positions herself as co-therapist, sharing the reflecting team members' view and aligning herself with the therapists' project to help James change. James, however, seems to challenge this positioning. He seems to ignore Maria's suggestions and explanations (lines 13, 16) and undertakes an increasingly agentic position, by clearly stating his own goal (that he wants to be able to get angry but not get into fights) and by reinterpreting his 'problem behaviour' (i.e. the fact that he doesn't answer back): he is not afraid of getting angry, as the therapists suggest, nor very shy, as Maria suggests; he does not answer back because he is thoughtful and considered, rather than quick-witted like his sister (lines 8-9, 11, 14-16, 17-19, 21, 23). This interaction is in stark contrast to the constructions that characterised the earlier parts of the therapy, where James was most often represented as at the mercy of his 'condition'.

In terms of the therapist-client interaction, James (lines 3-5) addresses the therapist, directly asking for advice and positioning the therapist as an expert, appealing to her age and professional status. This expert position seems to be one the therapist does not want to occupy; she responds (lines 6-7, 10, 22, 24-26, 28, 30) that she cannot tell James what to do and at the same time positions James as a responsible adult with the duty to live his life, according to his own choices. However, somewhat paradoxically, she simultaneously uses her expert authority to offer an interpretation (lines 6-7) that relies on a psychological discourse, according to which a well functioning self is in touch with feelings, and particularly with feelings of pain and anger (Burman, 1995). This could be seen as an example of an ideological dilemma (Billig et al., 1988), the tension between authority and equality that characterises contemporary social institutions, including psychotherapy (Avdi, Griffin, & Brough, 2000). Alternatively, it could be seen as a rhetorical strategy employed by postmodern

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therapists (Kogan & Gale, 1997), whereby she subvert her positioning as an expert on James' life by appealing to her not-knowing (lines 33), to the importance of personal experience (lines 35, 37), and by reframing James' problem as a common difficulty shared by many, including herself (lines 39-43). Thus the therapist simultaneously both uses and disowns her position as an expert on human nature; paradoxically, the primary position she occupies allows her to authoritatively determine that she cannot know what James should do.

### Discussion

In sum, positioning is considered a discursive and interactional process and, therefore, analysing therapy from the standpoint of positioning focuses on the interaction within which subjectivity is constructed in therapy, taking into consideration the context of talk.

A particularly useful aspect of analysing therapy by closely attending to talk is that therapy is approached as a collaborative process of meaning-making; as a consequence, the joint construction of new meanings in the therapeutic encounter is highlighted and the implication of various discourses in the client's difficulties can be discerned. By studying in detail features of the conversation, such as sequence organisation or the introduction of new topics, one can study who introduces what in the conversation and what participants do with each others' talk; this is very useful for studying the dynamics as they unfold. Moreover, the close attention to language and interaction can help sharpen the therapist's skills of attention and increase sensitivity to understanding clinical material (Avdi, 2008). At the same time, the 'distancing' generated through the processes of transcription and analysis may promote the generation of further interpretations and new insights regarding clinical material (Forrester & Reason, 2006). More broadly, therapists can become aware of the effects of their interventions on the client's narrative and can also monitor the extent of correspondence between the therapeutic assumptions they adhere to and their implementation in practice. In this way, such analyses can generate knowledge that is useful for training and continuing professional development.

Notwithstanding the potential of the notion of positioning for studying therapy, there are several limitations to the use of the notion in conceptualizing subjectivity that I consider below. One important limitation relates to a wider critique that has been termed 'discourse determinism', that is the assumption that culturally available discourses *define* experience, action and identity, a position that cannot account for resistance to dominant discourses or indeed change (Henriques et al., 1998). Although as already mentioned, the various attempts to theorise 'complex subjectivity' through the use of psychoanalysis have gone some way towards addressing this issue, it remains a point of tension and debate. Along similar lines, several authors challenge the primacy of narrative and language for selfhood and warn against the risk of over-emphasizing

the role of language to the detriment of other means of expression and identity construction (Wells, 2003). Broadly, these authors argue that focusing solely on language may function to sidestep other important aspects of identity construction, such as material and embodied aspects (e.g. Meehan & McLachan, 2009) and alternative, artistic modes of expression (e.g. Strawson, 2004). It is worth noting, however, that the concept of positioning does not necessarily preclude the performative and embodied aspects of subjectivity (Raggatt, 2007) and this aspect of positioning could be included in future studies of therapy. Secondly, the tendency to focus on the socio-discursive level runs the risk of placing individuals' personal experience backstage; this is particularly problematic when dealing with groups that have been traditionally marginalized or silenced in mainstream accounts. For example, several proponents of critical approaches to mental health have argued that accounts that focus almost exclusively on the socio-discursive aspect of pathology construction may fail to recognize and address the very real suffering experienced by people deemed 'mad' (Blackman, 2005). Thirdly, the notion of subject positioning tends to overplay the fleeting, disorderly and fragmented -like nature of self, which is not necessarily consistent with many people's subjective experience of coherence and continuity of self. Finally, it has been argued that theorizing the self primarily in terms of a category in talk runs the risk of reverting to some version of 'uncomplicated subjectivity' akin to a humanist version of the person as a reflective and autonomous agent (Georgaca, 2005).

### **Conclusions**

Although the notion of dialogical self in theory entails consideration of both the personal- dynamic and the social-discursive aspects of positioning (Raggat, 2007), in practice most of the research literature on therapy to date refers almost exclusively to the first aspect. This has led to the paradoxical position that dialogical approaches seem to promote an individualized view of the self and to sidestep the interpersonal nature of narrative production as well as the role of the wider sociocultural context in the content and structure of narratives. In this paper I have suggested that the notions of dialogical self and subject position are distinct yet related discursive tools that can be used to study therapy from a dialogical perspective. Moreover, the analytic tool of subject positioning offers the potential of studying therapy as an interaction, attending to the active role of therapists, and taking into account the powerful role of context in people's sense of self and in the course of therapy. As such, it may further attempts to synthesize the divide between self and culture, which underlies many of the theoretical differences in the dialogical self literature.

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