Deconstructing Therapeutic Discourse: identity and interiority

Desconstruindo o discurso terapêutico: identidade e interioridade

Deconstruyendo del discurso terapéutico: identidad e interioridad

Déconstruire le discours thérapeutique: identité et intériorité

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Abstract

This paper draws on the 'social constructionist' approaches in psychology and allied disciplines which question the truth claims made by academics and professionals about how our minds work and the way we behave. Part of the project of critical research in psychology that is concerned with the social construction of psychological and psychotherapeutic phenomena is to look at the broader cultural conditions in which we speak about these things. Therapeutic discourse, according to this perspective, needs to be analysed in the context of 'psychological culture'. The paper develops an analysis of therapeutic discourse to understand how the identity of psychotherapists is performed. Deconstruction of identity in psychotherapy is in this way also turned to the task of deconstructing the notions of interiority that sustain psychotherapy in contemporary psychological culture.

Keywords: *Therapy, discourse, deconstruction, identity, interiority*

Resumo

Este artigo parte das abordagens "sócio-construcionistas" em psicologia e disciplinas correlatas, que questionam os preceitos sustentados por acadêmicos e profissionais acerca de como nossas mentes funcionam e a maneira como nos comportamos. Parte do projeto de pesquisa crítica em psicologia, que se ocupa da construção social de fenômenos da psicoterapia e psicologia, dedica-se a olhar para as condições culturais mais amplas a partir das quais tratamos desses temas. O discurso terapêutico, conforme essa perspectiva, deve ser analisado no contexto da "cultura psicológica". O artigo desenvolve uma análise do discurso terapêutico a fim de entender como a identidade de psicoterapeutas é atuada. A desconstrução da identidade em psicoterapia volta-se também, dessa forma, à tarefa de desconstrução das noções de interioridade que sustenta a psicoterapia na cultura psicológica contemporânea.

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***Como citar**: Parker, I. (2017) Deconstructing Therapeutic Discourse: identity and interiority. Psicologia Política, 17 (40) p. 443-453.*

Palavras-chave: *Terapia, discurso, desconstrução, identidade, interioridade*

Resumen

El articulo parte de las perspectivas "socio-construccionistas" en psicología y disciplinas cercanas, que cuestionan los preceptos sustentados por académicos y profesionales sobre como nuestras mentes funcionan y la forma como comportamos. Parte del proyecto de investigación critica en psicología, que se ocupa de la construcción social de fenómenos de la psicoterapia y psicología, dedica-se a mirar para las condiciones culturales más amplias desde las que tratamos eses temas. El discurso terapéutico, para esa perspectiva, debe ser analizado en el contexto de la "cultura psicológica". El artículo desarrolla un análisis del discurso terapéutico para entender como la identidad de psicoterapeutas es actuada. La desconstrucción de la identidad en psicoterapia vuelve también, así, a la tarea de desconstrucción de las nociones de interioridad que sostiene la psicoterapia en la cultura psicológica contemporánea.

Palabras clave: *Terapia, discurso, desconstrucción, identidad, interioridad*

Résumé

Cet article s'inspire des approches «constructivistes sociales» de la psychologie et des disciplines connexes qui remettent en question les affirmations de vérité faites par des universitaires et des professionnels sur la façon dont notre esprit fonctionne et sur notre comportement. Cet article porte sur le sujet de la psychologie, et s'intéresse à la construction sociale des phénomènes psychologiques et psychothérapeutiques. Le discours thérapeutique, selon cette perspective, doit être analysé dans le contexte de la «culture psychologique». L'article développe une analyse du discours thérapeutique pour comprendre le spectacle de l'identité des psychothérapeutes. La déconstruction de l'identité en psychothérapie est également en train de déconstruire les concepts de maintien de la psychothérapie dans la culture psychologique contemporaine.

Mots-clés: *Thérapie, discours, déconstruction, identité, intériorité*

Deconstructing therapeutic discourse: identity and interiority

Recent years have seen the emergence of 'social constructionist' approaches in psychology and allied disciplines, and these approaches question the truth claims made by academics and professionals about how our minds work and the way we behave (e.g., Burr, 1985; Gergen, 1999). These truth claims are treated as narratives, stories or 'discourses' about psychological processes, and so social constructionism has been attractive to those working the new field of 'critical psychology' (Parker, 1999a). Part of the project of critical research in psychology that is concerned with the social construction of psychological and psychotherapeutic phenomena is to look at the broader cultural conditions in which we speak about these things. Therapeutic discourse, according to this perspective, needs to be analysed in the context of 'psychological culture' (Gordo and De Vos, 2010). This paper is part of that broader critical project (Parker, 2009).

We need to take the analysis of discourse seriously if we want to understand identity, in this case the professional identity of psychotherapists. Discourse comprises patterns of speech and writing, and other systems of meaning that include advertising, film and television, all of the places where there are messages about what the world is like (Parker, 2002). Discourse not only produces pictures of the world and the things in it but also prescribes what the *subjects* who inhabit it are like. Therapeutic discourse is a cluster of meanings to do with how people should feel and what they should say to be understood by others to be mentally healthy, or at least with what is presumed to be healthy awareness of their mental ill-health. It is a discourse that is becoming increasingly powerful in contemporary Western culture (Parker, 2007).

When therapeutic discourse sets out positions for subjects to adopt so that they can speak and be understood it does not merely lay out empty spaces in language that invite us in. When we take up a speaking position in discourse we do not do so in the same way as we might choose clothes from the wardrobe. Although it may be possible to speak cynically, to engage in what Goffman (1971) called 'role distancing' in our performance, we are also still even then taking a position. To engage in role distancing is still to communicate something about our relation to what we are doing, or to the discourse we speak, to others. This analysis owes much to the kind of close description of the way we perform our selves to others that Goffman exemplified, but it is also framed by the historical and institutional analysis provided by Foucault (1979, 1981). Most of the time we must speak in forms of language, and so in discourse we cannot control; in discourse that inhabits and moves us in ways that operate outside immediate awareness. The contradictions and functions of this language are what methodological approaches like discourse analysis have made apparent (e.g., Potter and Wetherell, 1987), and which Foucauldian approaches to discourse analysis have situated in wider processes of culture and power (Parker, 2002).

There is something special about therapeutic discourse that draws us all the more tightly into its code, into its network of assumptions about the world, people and the insides of their minds. Therapeutic discourse includes, for example, deliberate attention to cynicism as a problem, and there is a requirement that there should be a depth of commitment to it as one speaks it that makes it difficult to step back out of when one has finished speaking it. I will return to these characteristics in more detail in a moment. To speak in a position therapeutically, is to perform subjectivity in such a way as to never be able to perform any other position again in the same way.

Therapeutic discourse also functions within certain apparatuses of care and responsibility that conceal at the very moment that they reproduce patterns of power in the broader domain of the psy-complex. The psy-complex is the network of theories and practices to do with 'psychology' in academic departments, clinics and popular culture which discuss and determine how people should behave and think (Ingleby, 1985; Rose, 1985). For example, 'C&R' in the British Special Hospitals some years ago used to stand for 'Control & Restraint' and described the procedure for wrestling to

the ground and medicating impatient prisoners. The procedure is still called 'C&R', but now in many places it is resignified to mean 'Care & Responsibility'.

Although forms of discourse analysis have been useful in tracing the contours of therapeutic discourse in transcripts of sessions (e.g., Siegfried, 1995), there is an understandable reluctance to speculate what people are actually thinking and feeling while they speak or write within the discourse. How can we explore the kinds of subjectivity constituted by discourse and relatively enduring effects on subjects who enter a discourse without psychologising, without reducing our level of explanation to what is going on inside individual heads? Psychologistic reduction is such a powerful invitation in contemporary culture, in our Western psychological culture, that it would be irony indeed if our understanding of therapeutic discourse, which does thoroughly individualise social phenomena, was to fall into that kind of trap (see Gordo-Lopez, 2000). But that is the task of this paper, and I pursue this task by attempting to grasp forms of subjectivity constituted in therapeutic discourse as 'therapeutic identity'.

Through the motif of therapeutic identity I also turn the analytic gaze back upon the professionals who service the psy-complex, those who usually benefit from it and who are able to determine what is healthy and unhealthy, what is normal and abnormal. It is important to point out, however, that they suffer too. In fact, one of the characteristics of therapeutic identity is that it is the therapeutic professional who suffers first before they invite others to experience the effects of therapeutic discourse.

There is nothing accidental about this, and it will be no surprise to those who have read Foucault's (1979) account of the development of forms of confession in Western culture that accompany the increasing observation and regulation of populations. The spiral of confession, which has its deepest roots in the Catholic confessional and which intensifies through the nineteenth and early twentieth century with the emergence of psychoanalytic confession on the couch, corkscrews its way down into the population from the bourgeoisie and petit bourgeoisie. The obsession with internal secrets, often sexual secrets, is something that is aristocratic and then middle class and which only then recruits the working class. As Foucault (1979, p. 120) argues: 'the most rigorous techniques were formed and, more particularly, applied first, with the greatest intensity, in the economically privileged and politically dominant classes'.

One only has to look at the class composition of the British psychoanalytic community to see the bourgeois, even aristocratic historical origins of therapeutic discourse maintained, sedimented to the present day (Young, 1999). Psychoanalytic training institutions have usually in most countries drawn their cadre from the most privileged social layers, and all the more so in the groups attached to the International Psychoanalytic Association (IPA), which in Britain is based at the Institute of Psycho-Analysis. Training, for which it is near impossible to receive financial support, requires five times a week analysis which must be paid for in addition to training fees. One will also find in the psychoanalytic and therapeutic community a class hierarchy that often overrides hierarchies of gender oppression, and it is thus able to tolerate women from the right background (even those who are not as high class as Princess Marie Bonaparte). That is, class and the inclusion of women from middle-class backgrounds, is often more important than gender. This does not mean that gender is unimportant. That many women participate in analytic and therapeutic institutions gives to therapeutic discourse some particular characteristics and consequences to its analysis.

The class hierarchy in psychoanalysis does dovetail more neatly with patterns of racial oppression, even if there are exceptions, and a grudging acceptance of upper class members like Prince Masud Khan (Hopkins, 2006). This class hierarchy also maps onto and reproduces the hierarchy between psychoanalysts, psychotherapists and counsellors. One of the things at stake in how we speak therapeutically as professionals at different levels in this pyramidic structure, then, is

how seriously we are taken by those around us. One of the peculiar and entrancing characteristics of therapeutic discourse is that we achieve our position not only, or even not even, by displaying knowledge but by displaying our *interiority*. But how does this discourse enable and encourage us to do this? The main section of this paper describes its main characteristics.

Therapeutic identity

I shall describe three components of therapeutic identity, that of the 'self', 'emotions' and 'relationships', but the distinctive sense of each of these components lies not so much in what each is supposed to be, and how each is spoken about in therapeutic discourse, as in how they are interrelated. This interrelationship is crucial, and I argue that the therapeutic self only works because there are certain assumptions about the nature of emotions and relationships, that emotions for therapeutic subjects have a crucial role in defining the self and relationships, and that relationships are the necessary medium for elaborating a therapeutic sense of self and emotions. Studies of the social construction of emotions have shown that feelings we take for granted as the bedrock of our being are constructed quite differently in different cultures (e.g., Harré, 1986).

This issue is particularly important to bear in mind when we studying therapeutic culture, for here emotions are often treated as final courts of appeal for what we understand to be truth. A second characteristic, one that this particular 'indigenous psychology' has in common with many others, is that it operates through a series of binary oppositions (cf. Heelas and Lock, 1982). In the case of therapeutic identity this binary oppositional quality is given, at least in part, by the way in which each of the three components calls upon the others, but there are other aspects of this bipolar organisation of self, emotions and relationships that are also important. At the very least, binary oppositions do facilitate the presentation of the analysis.

We can find modes of therapeutic discourse in clinical arenas that require that we adopt a certain notion of the individual to work, in popularisations of therapy in different media which actively encourage people to adopt such a notion of the individual, and in theoretical reflections on therapy in academic and professional texts which assume or argue for therapeutic identity as the norm. It is worth pointing out that the theoretical texts I focus on in this paper are not 'outside' the phenomenon but they are designed to invite the reader to engage in the discourse in such a way as to use the texts to rehearse and elaborate what therapeutic individuality should be like. Here there are certain kinds of theoretical text that operate didactically, not so much through the direct application of therapeutic categories but through framing and re-elaboration of experiential phenomena (e.g., Phillips, 1994). Let us take the self first.

- ***Self***

My concern here is with how the self functions in relation to emotions and in relationships. I refer to these selves structured by therapeutic identity as 'therapeutic subjects'. Therapeutic subjects are those who practice as psychotherapists and those who have become skilled practitioners of therapeutic discourse either by being clients in counselling, therapy or analysis or by being attentive readers of therapeutic texts. There are three motifs, of depth, fragility and morality.

Depth. One key therapeutic motif is that the self is treated as something that is deep under the surface. Take, for example, the way therapeutic subjects talk about 'hearing' and 'being heard'. In therapeutic talk 'hearing' and 'being heard' has a slightly different meaning than in normal speech. When we say 'I don't know if you really heard me', there seems to be an image of something inside, so you can physically hear something. However, therapeutic discourse is framing this in such a way

as to assume that there is some deeper self inside that could really 'hear' or 'not hear' what is being said. The notion of 'hearing' and 'being heard' are talked about as requiring some deeper or beneath the surface emotional reception which is more profound than simple acoustic reception.

With respect to the question of self and emotion, There is a hint here of a quasi-Cartesian homunculus inside the shell of the body. But this is not properly Cartesian because the mind is in some ways treated as equivalent to the self, and the self is not treated as separate from the body. Bodily pain, in therapeutic discourse, is necessarily also mental pain, and in some ways it is a magnification of it and it resonates with it.There is a kind of displacement from body to mind of key emotions, as if from the hard shell of the individual to the softer more tender self inside, so that, for example, something being 'painful' should be felt at the interior of the self rather than at the physical limits of the body.

With respect to self and relationships, there is a paradox here, which is that all the deeper we go all the more powerful is a felt need for connection with others.

Fragility. A second motif is that the self is thought of as being fragile. Now, of course, human beings are quite fragile, but this fragility is much more intense in therapeutic discourse. So, for example, if someone has had an accident or been robbed, a therapeutic subject will talk about them as being 'violated'. Again, there are notions of depth here, a deep self who has been affected by physical pain, but there is an idea that we are very fragile and sensitive.

When we speak from deep within therapeutic discourse we will show our sensitivity and pain at stories about others and look very very concerned as if we too were hurt deep in our selves about bad things. Now, I should be clear that I'm not saying it's a bad thing to be concerned about others. What I am drawing attention to is the way that this is played out in a certain kind of therapeutic talk.

Fragility is itself a moral example which indicates sensitivity, but a certain kind of sensitivity which is sensitivity to others. There is also a notion of contamination which frames how relationships or other exposure to external images will affect the self.

Morality. The third motif is that the self should be a moral example to others.

You will have noticed, perhaps that therapists often lead a public life as a moral example. They live in an ambassadorial role. That is why they are sometimes a bit santimonious and humourless. Those who are really drawn deep into their therapeutic identity seem very conscious about being good people who will be a moral example to others.

The therapist will often need to model emotions as they communicate how a situation should be understood. This is theorised in group analysis in the argument that the conductor needs to become 'the representative of the analytic attitude in the group' (Foulkes and Anthony, 1957, p. 28). This is drummed home in the use of psychoanalytic theory to explain how people manage everyday relationships, and how they should do so. When these writers talk about 'fantasy in everyday life', the underlying message is that you must take this seriously and adopt certain rhetorical strategies to negotiate your own fantasies and the fantasies of others (e.g., Segal, 1991).

The self is reflexively treated as a performance to others in this kind of writing, even if the authors simply believe that the performer is being open to their own feelings. This performance requires a degree of skill. But this skill is not merely the individual skill of the therapist performing their role as moral exemplar. It requires the assent, and often the support of the audience. Goffman puts it this way, when talking about performance in general: 'if a performance is to be effective it will be likely that the extent and character of the cooperation that makes this possible will be concealed and kept secret (Goffman, 1971, p. 108).

Let us move on to emotions in therapeutic discourse.

- ***Emotions***

What is important here is the way emotions operate in and around the self and through the medium of relationships. In the case of emotion talk in therapeutic discourse we come across a kind of paradox. Although the self is deep, emotions are very much in relation to others. There have been many studies of the ways that emotions are spoken of it different ways in different cultures around the world, and among therapeutic types we find particular assumptions about the way emotions operate.

Observability. First, there is an assumption that the feelings are directly observable, and that they can be directly observed in others, perhaps more easily so than in the self.

The theoretical elaboration of this is to be found in the infant observation requirement of British psychoanalytic and psychoanalytic psychotherapy trainings. When Melanie Klein, one of the founders of analysis in this country, was asked whether an analyst was really able to directly observe psychic processes and emotions like envy she pointed at the infant and demonstrated the accuracy of such observation and judgement by saying 'now they are envious, now they are not'. It is underpinned also by the peculiar power that empiricist discourse holds in Britain, a discourse which is then exported to the rest of the world (Easthope, 1999). (Actually, in a further colonial twist to this story, we should note that what is sometimes called 'English empiricism' was elaborated by philosophers who were part of the Scottish Enlightenment tradition.)

There is often a polarity between sensation in relation to others and knowledge, and a drive to know about others. The ability to make categorical statements about the objective existence of emotions is sometimes conceptualised as not as necessarily lying inside the self but as lying in a space between people or in groups; for example in the statement that 'it is painful' or the interpretation that 'the group is angry'

Intuition. Second, there is a notion that emotions can be intuitively grasped, and this is something that the therapeutic training will often promise access to.

There is an opposition at work between thinking and feeling and so a privileging of direct intuitive access to feeling over rationalisation. There is in some arenas, as a consequence, a refusal of theory as a kind of defence. So, to take up a therapeutic identity and to display it to others is to show that we know what other people are feeling. We are able to say things like 'you are angry with me' or even that a group of people might be angry, or be in some other emotional state.

This importance given to emotions as being able to be intuited is, I think, because the emotions are not only treated as inside the self, as deep, but as 'between' people in some way. Again, I am not saying this because it is necessarily wrong. That is not the point of this kind of analysis, but that there is this assumption made in the way that therapeutic talk operates. Here inside and outside are mapped onto feeling and expression but emotion here is not simply to do with accumulation and discharge. Rather, it is in the seeking of speech and expression.

Moralising. Third, there seems to be a strong idea that emotions are bound up with morality. What I mean by this is that some ways of feeling and showing your feelings are treated as healthy and good. This moralising of emotions is brought about in therapeutic discourse through resignification and investment of everyday words with emotional force, words such as 'special', 'important', 'painful', 'hard'. When these words are said in a therapeutic way they are very much more important, with a greater moral weight than in everyday speech.

Another expression of this here is that the phrase 'how do you feel' is said as if it carries a necessarily solicitous quality, is designed to evoke and brings forth something that is 'felt' beneath

the level of language. This also conveys, performs, the emotion of 'concern' for what others may be feeling.

Now, having talked a little about self and emotions in therapeutic identity, let us move on to relationships.

- ***Relationships***

Here we will focus on the way relationships structure the self and operate as a medium for emotions.

Connection. There is a theme running through therapeutic talk of connection, that we need to connect with others, that people are deep down 'needy' for connection. You can see this at work in the way that the discourse of touching works. There is a big importance given to what it is to be 'touched', and of course being 'touched' by someone is not only physical; it has very strong emotional meanings to do with connection with what someone is saying and what you feel, and those emotional meanings now bleed into discourse about touching in education, for example (Piper and Stronach, 2008). There is lots of discussion in therapeutic circles about whether therapists should or should not touch their clients. Now, again, I am not saying that these issues are not important. They are. Here I am focusing on the power they seem to have in therapeutic talk. When we speak of touching in therapeutic discourse there is an emphasis both on the importance of touching and upon the witholding of touching. There is a polarity being presupposed between need and restraint. This is where there is a moral evaluation of connection.

Exteriority. A second aspect of therapeutically framed relationships is the way that the self and emotions are performed in such a way that there is quite strong crossover here between therapeutic circles and dramatic circles.

It is striking the way that therapeutic talk is often accompanied by a kind of dramatic acting out of what the emotions are that are supposed to be in the talk. Sometimes this appears in big hand and arm movements and swaying of the body, and sometimes in exaggerated expressions on the face. There will also often be a certain mode of speech to indicate sensitivity to the reactions of others, in 'upspeak', for example.

It is worth noting that sometimes we see the complete opposite, in the humourless therapeutic types, in some hard-line psychoanalysts, for example, who will do their best not to act out emotions as they speak. Either way we see the importance attached to the exteriorisation of emotions as part of the performance of therapeutic identity.

Boundaries. A third motif in relationships is the importance given to 'boundaries'. We often find in the performance of therapeutic identity an oscillation between boundary-mania or boundary-phobia. This is where we will find talk about 'containing' emotions and talk about 'safe places'. Again, this is important. What I am saying does not mean that these issues are not important, but there are some worrying consequences. It can reach a point, for example, when therapists are so worried about what they call 'boundaries' that they cannot be involved in public political activities because their clients might see them or interact with them outside the therapeutic space.

This is where we see boundary modelling, and an injunction on clients to respect boundaries. These injunctions may be either explicitly formulated or implicit, hinted at. They also mark a division between public life and private life, which in the therapeutic space are actually necessarily blurred.

One example is in the importance given to boundaries as forms of protection.

The analysis of therapeutic identity in context

There are difficulties in capturing a new indigenous psychology of this type because it operates as a subculture, albeit an increasingly powerful one in Western culture, which overlaps with other similar subcultures. Therapeutic identity shares certain modes of expression, for example, with the acting profession (and a way of reflecting on dramatic work which is mercilessly derided in the 'luvvies' quote box in Private Eye, for example).

It is important not to abstract this kind of analysis from context, as if therapeutic discourse has formal qualities independent of its wider 'conditions of possibility'. We need to embed this analysis in a broader analysis of the discursive conditions in which therapy operates in Western culture. These conditions are as much cultural as institutional. The question of 'culture' here impacts on the analysis not only in the way that psychotherapy exists in a certain 'sub-culture' but also in the way that it exists in relation to other cultures and sub-cultures. Both the cultural and institutional conditions are interwoven with questions of gender.

One striking characteristic of therapeutic practice has actually been the presence of many women in its institutions, and an increasing number in the last twenty years or so as feminist activists (along with a significant but smaller number of male leftists) turned to therapy and trained as analysts, therapists or counsellors. In recent years this has also meant that therapy has been the chosen medium for radical activity for lesbian feminists (and to a lesser extent for gay men). And one consequence of what we might term the 'feminising' of therapeutic discourse has been that the backlash to therapy evident in the activity of the various 'false memory' groups in the US and Britain has also been a backlash against feminism, perhaps in some cases a primary motivating force.

The gender composition of therapy not only has consequences for the way therapeutic discourse and therapeutic identity should be understood but also for the consequences of developing an analysis, and by implication, critique in the first place. The rise of therapy is concurrent with the increase in importance of the service sector in late capitalism, and this service sector calls upon women to engage in what has been called 'emotional labour' which entails 'deep acting', the performance of an ostensibly genuine 'relationship' with the customer (Hochschild, 1983).

There is thus also a political aspect to this kind of analysis, and the functions of the analysis in the public domain are as important as the material that the analysis has been concerned with. There is an opposition between discourse analysis, which ironises truth claims about the self, emotions and relationships, and therapeutic discourse, which takes them at face value. Discourse analysis thus risks being heard as being disrespectful of experience and of failing to honour experience in the way therapeutic subjects have learnt to do.

The analysis also raises more general issues about the way we should understand the self not as the source but as an effect of discourse, and this too will be unsettling to therapeutic subjects.

You will have noticed that the therapeutic discourse is organised around binary oppositions – between inside and outside, between self and others, between depth and surface, and so on – and this makes it ripe for deconstruction. Deconstruction can be used as a procedure inside therapy in order to enable the client to 'externalise' the problem and explore the construction of a problematic identity in discourses that surround them (Parker, 1999). This analysis takes that kind of work back out into the therapeutic frame that can itself function to re-pathologise those who were, perhaps, being weaned off the standard individualising therapeutic approaches – cognitive behavioural, humanistic and psychoanalytic – because they do not 'respectfully' adhere to the modes of discourse that were used to help them.

This 'deconstruction' of therapeutic discourse has implications for the very notion of the self that is presumed in much psychotherapy, including psychotherapy that employs 'deconstruction'.

Goffman makes the point that: 'this self itself does not derive from its possessor, but from the whole scene of his [sic] action, being generated by that attribute of local events which renders them interpretable by witnesses' (Goffman, 1971, p. 244). So, if we take this seriously, and I think we should, we then need to ask how the therapeutic encounter itself operates as a 'scene' in which there is a normalising of a certain way of a speaking and so of a certain way of behaving.

So, our work includes deconstructing the too-easy game of singling out the therapists as manipulative rhetoricians who are trying to persuade us to speak as they do. Deconstruction attends to the textual, discursive patterns that privilege the 'author' as source of language, and so our deconstruction must look at the way those who position themselves as a willing audience for the therapists, and as speakers of this discourse in their own therapy, are complicit. The insistence that linguistic strategies used by people to talk about their feelings, that they should 'emotionally literate' is of a piece with what has been termed 'Verbal hygiene' in contemporary culture (Cameron, 1995).

Conclusions

A focus on therapeutic identity is not mere tactical pathologisation of professionals, a repetition of the argument, for example, that it is the psychiatrists rather than the patients who are mad, to insist that the active practitioners of therapeutic discourse suffer it first. Nevertheless, this point is necessary if we are to hold onto an understanding of the way forms of subjectivity and interiority are produced in discourse. Therapeutic identity is a particular mode of understanding and self-understanding which is laced together through certain practices of speech, writing and performance.

What I call 'therapeutic identity' in this paper, or a therapeutic way of speaking, is not only something that therapists do. Clients who have learnt to talk in a therapeutic way are often very keen to persuade other people to talk in that way as well. And more and more people now do talk in a therapeutic way, and they also craft for themselves a therapeutic identity. I call it 'therapeutic identity' to make it seem a bit strange, to draw attention to it, to diagnose it as part of the talk of the professionals in the psy-complex. Then we can think better about the effects it has and whether we want to avoid it or make use of it.

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Submited at: 25/10/2015
Accepted at: 30/03/2016