9

The Contexts of Psychotherapy

1. Because we're here in a therapeutic environment, so, everything so small can have meaning, I guess.
[FC T cl 143]

2. It's easier to pretend to be normal when you aren't seeing two doctors a week
[S1 P6 cl 138]

3. P Do other people ask you questions?
T Mm
P It's just like to make me feel more normal
T Absolutely
[FC cl 162]

4. Do you have to like the people you see?
[FE cl 192]

9.1 Introduction

The last four chapters have described the lexicogrammatical patterns of the different text types, which together create a complex tale of self in psychotherapy. Just as the lexicogrammatical chapters display the meanings of the wordings, this chapter now considers the meanings of the context, where context is *the total environment in which the text unfolds* (Halliday and Hasan 1985:5). This chapter specifically explores the dialectic relationship between context and lexicogrammar that creates Scripts (section 9.6), Chronicles (section 9.5) and Narratives (section 9.7) within a general context of psychotherapy (section 9.4).

Chapter 2 introduced the theoretical underpinnings of context in both SFL and the Conversational Model. It proposed that, although 'context' is generally undertheorised by the Conversational Model, the model does describe the contextual clinical difficulty of creating intimacy and 'spontaneous' language in an institutional setting with a hierarchical structure (Meares 2001b:766). In the intervening chapters this contextual difficulty has been left to one side as the lexicogrammatical contribution to the various realisations of self in Scripts, Chronicles and Narratives was presented. In those lexicogrammatical chapters,

Chronicles showed the patients' self as a syndrome of ineffectuality, Scripts revealed an alienation of self from the normal world, and Narratives showed the possibility of an alternative normality, which is achieved through imagination or memory.

To fully understand the creation of these variations, it is necessary to examine the interplay between the static institutional context of psychotherapy (hereafter called the canonical context, which is explained below) and the unfolding dynamic context of Scripts, Chronicles and Narratives. This chapter first explores the canonical contextual configuration and then shows how Scripts, Chronicles and Narratives are created by and simultaneously create the different contextual configurations which were realised in the lexicogrammar. This chapter also returns to Meares' clinical difficulty (see above) to closely investigate the contextual configuration which maps the contextual tensions of intimacy and institution in therapy.

The citations that introduce this chapter demonstrate the contextual tension. The first two draw attention to the institution of therapy and the impact on self. The third citation *Do other people ask you questions?* foregrounds the tension when a patient asks a personal question to a therapist to *make me feel more normal*, while knowing it is against therapy 'rules'[80]. The fourth citation *Do you have to like the people you see?* also demonstrates a contextual breach, which foregrounds that friendship with the therapist is very important and normalising for patients.

Friendship as a concept is also important for therapists, with the contextual tension highlighted in their theoretical writings. Chapter 2 described how, in psychotherapy, Hobson understood that 'friendlike talk' between patients and therapists created valued therapy, even though it was against institutional cultural expectations, where professional distance is an essential pillar of the professional ethics of psychiatry (Meares 2001b:766), see section 2.5.13. While therapists theorise the context of their sessions against background canonical professional expectations, patients contrast this context against their own personal 'canonical' expectations of normality[81].

The tension between the need for the intimacy necessary for the development of self and the maintenance of institution required by professional ethics raises two fundamental questions about therapy: (i) Can therapists clinically balance the tension between intimacy and

[80] The patient's knowledge of the breach is demonstrated by a later question, *I didn't mean that to be – you weren't offended by that, are you?* (Turn 146)

[81] Bruner refers to this contrast as 'Human beings, in interacting with one another, form a sense of the canonical and ordinary as a background against which to interpret and give a narrative meaning to breaches in and deviations from 'normal' states of the human condition' (Bruner 1990:67).

professional ethics to establish an environment where patients can create texts that help them to regain a normal self, and therefore indicate improved mental health? (ii) Can patients develop their own desires for intimacy so that they can develop a sense of a normal self, while remaining within the boundaries of the institutional context? Thus the intersubjectivity[82], or configuration of patient/therapist relationship, is integral to creation of therapy talk.

This tension between necessary intimacy and necessary institution creates perturbations in the context with the potential for therapy to either 'fail', in this case, to immediately produce a Script or in the long term lead to cessation of therapy, or 'succeed', in this case, to immediately produce a Narrative or in the long term improve mental health. A close mapping of both the canonical context and unfolding dynamic context contributes to the investigation of the questions raised above.

The chapter proceeds in the following order: section 9.2 briefly introduces a general view of context, and section 9.3 introduces context networks as the analytical tool for this chapter; section 9.4 presents the canonical context and sections 9.5 to 9.8 presents the dynamic contexts of Scripts, Chronicles and Narratives; sections 9.9 and 9.10 present contextual breaches as therapeutic cruces. Section 9.11 concludes the chapter. Chapter 10 continues this exploration of the context stratum with an investigation of the generic structure of the texts.

9.2 LOCATING THE CORPUS IN CONTEXT

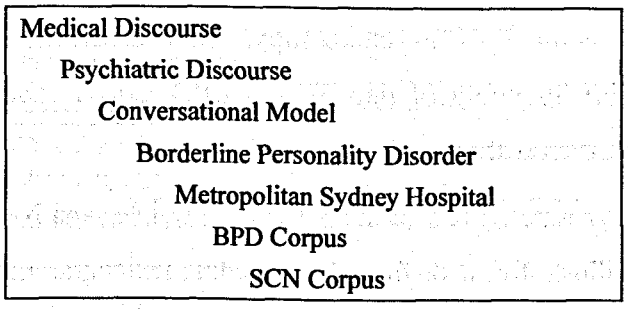

Figure 9.1 The SCN Corpus within Medical Discourse

Figure 9.1 above locates the SCN Corpus within medical discourse. In this figure Scripts, Chronicles and Narratives are located as spoken text types first within the SCN Corpus and then within the BPD Corpus. These corpora occur within the Conversation Model of psychotherapy used to treat people with borderline personality disorder in a metropolitan Sydney hospital. The Conversational Model is a spoken psychiatric discourse, which itself

[82] Trevarthen's term (see chapter 2), which Meares uses to describe the relationship space between the participants where patients do the work of recreating the inner self (Meares 1993:25).

occurs within the extensive field of medical discourse, an area that has been well studied within different linguistic paradigms (see Charon 1996 for a general overview).

Figure 9.2 below locates Scripts, Chronicles and Narratives linguistically within a specific register of spoken language, within the broad register of spoken medical discourse. The SCN Corpus occurs on a cline, between 'casual conversation used for professional purposes' (Candlin 2000:241) and texts elicited in interviews, and alongside other naturally occurring talk in health professional/patient dyads, for example, Moore's HIV consultations (2003). Field and tenor are described in section 9.3 below.

Spoken Medical Discourse		
Casual Conversation for professional purposes	**Naturally occurring Psychotherapy Talk**	**Elicited Interview Discourse**
Free field	"Free field"	Control field
Equal tenor	Control tenor	Control tenor

Figure 9.2 The Cline of Spoken Medical Discourse

9.3 Mapping the Context

In chapter 2 the SFL description of context was briefly introduced by the categories of field, tenor and mode. This chapter uses Butt's context networks to explore these categories more delicately in order to examine the finer distinctions in the dynamic contexts of Scripts, Chronicles and Narratives. Each network maps:

1. The canonical context of psychotherapy. This description is drawn from my engagement with 30 hours of data in the BPD Corpus and from the theoretical writings of the Conversational Model.
2. The unfolding dynamic context of the Scripts, Chronicles and Narratives, with particular reference to the illustrative texts from the preceding lexicogrammatical chapters.
3. The simultaneous creation by therapist and patient.

9.3.1 The Context Networks

This chapter explores context through the use of context networks. The context networks are developed by Butt (2002) as an extension from the networks of Hasan (1999). Each contextual parameter, that is, field, tenor and mode, is drawn as a network system of simultaneous and parallel domains of contrast. Each domain of contrast is then developed through a pathway of degrees of delicacy. Although the networks, as drawn on paper, appear binary, Hasan emphasises that the networks are a 'continuum rather than a binary division'

(1996:297). For example, there is a continuum between the categories of [SPECIALISED] and [QUOTIDIAN] spheres of action. The system network choices and conventions are presented in Appendix E, alongside the complete field, tenor and mode context networks. Following Butt 2002, Hasan's terms are in small capital letters and Butt's are in normal font. In this chapter all technical terms from the networks are bracketed for ease of reading.

The domains of contrast and their definitions are briefly introduced in the next sections, sections 9.3.2 and 9.3.3, as analytic tools, before presenting the full context analysis in sections 9.4-9.8.

9.3.2 Domains of Contrast

This section presents the first level of domains of contrast for field, tenor and mode. The full definitions for all the terms of the networks can be found in Butt 2003. Each domain of contrast presented below provides the entry point to the network selections presented in section 9.4.

Field 'refers to the nature of the social interaction: what it is the interactants are about' (Halliday 1994:390). Field is realised in the experiential metafunction in the transitivity system.

Domain of Contrast	Description
SPHERE OF ACTION	Describes the subject matter of the interaction
MATERIAL ACTION	Describes the extent to which the material action is an obligatory part of the interaction in context
Action with Symbols	Describes the nature of the semiotic activity within the context
GOAL ORIENTATION	Describes the goals of the interaction in terms of timeframe, explicitness and their alignment amongst the participants

Table 9.1 Domain of Contrast Terms for Field Network (adapted from Butt 2003)

Tenor 'refers to the statuses and role relationships: who is taking part in the interaction' (Halliday 1994:390). Tenor is realised in the interpersonal metafunction in the mood system.

Domain of Contrast	Description
SOCIAL HIERARCHY	Describes the status /power relations between the participants in the context, how this is reflected in the semiotic devices used in the text, and whether this is able to change within context
AGENTIVE ROLE	Describes the nature of the actant roles of the participants in the context
SOCIAL DISTANCE	Describes the social distance between the participants by reference to multiplicity of relationships, types of interaction and codal sharing/distinction
Network Morphology	Describes the social network of which the participants are members

Table 9.2 Domain of Contrast Terms for Tenor Network (adapted from Butt 2003)

Mode 'refers to the rhetorical channel and function of the discourse: what part the text is playing' (Halliday 1994:390). Mode is realised in the textual metafunction.

Domain of Contrast	Description
Role of Language	Describes the extent to which language constitutes the activity
Channel	Describes how the language is delivered
Medium	Describes the organisation of the language

Table 9.3 Domain of Contrast Terms for Mode Network (adapted from Butt 2003)

9. 3.3 Artefacts of Analysis

The contextual parameters field, tenor and mode are permeable categories (Hasan 1999:244) and occur simultaneously in practice[83]. However, for analytic purposes they are drawn as separate networks and discussed; first individually and then as a combined contextual configuration. The bulk of the discussion is in the field network in order to match the lexicogrammatical chapters, where the experiential metafunction was the major focus of discussion.

Sections of the networks are presented with discussion in this chapter. The patient network is marked in red and therapist in blue. The complete networks are in Appendix E, pp 382-384.

[83] This is the same for all SFL analysis, for example, the ideational, interpersonal and textual metafunctions also occur simultaneously but are separated for analysis, as was seen in chapters 5,6 and 7.

PART I: THE CANONICAL CONTEXT

9.4 THE THERAPY CONTEXT

This section describes the contextual parameters which create the canonical context for Scripts, Chronicles and Narratives. It follows the context networks of Butt in the following order: field, tenor and mode. Each network is discussed in sections according to their first domain of contrast presented in section 9.3 above and illustrated by relevant sections of the context network. The placement of each section within the full context network is in Appendix E, pp383-385.

9.4.1 Therapy Field

1. SPHERE OF ACTION

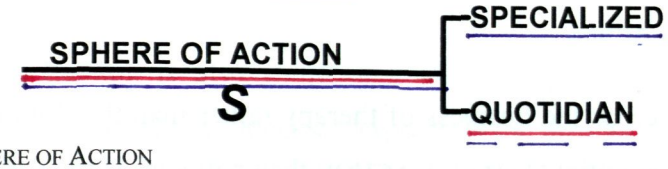

Figure 9.3 Field SPHERE OF ACTION

SPHERE OF ACTION highlights the tension in the context between [SPECIALISED] and [QUOTIDIAN]. Therapists are only present because of their specialisation, recognised in their qualifications, which are gained after many years of training. The specialisation is highly theorised by therapists around the field of knowledge of 'self' (which immediately displays the tension between the [SPECIALISED] theory and the creation of 'self' which occurs in the [QUOTIDIAN]).

This specialisation is realised as a feature of the semantics and grammar, rather than the lexis, because patients have a [QUOTIDIAN] SPHERE OF ACTION. The rare references by therapists to medical terminology, for example, *psychosis* are tempered by colloquial lexis, for example, '*bread and butter' psychosis* to accommodate the patients' lack of specialisation. Therapists' specialization is also realized; in the tenor, in, for example, (i) the therapists' right to not talk about themselves nor answer questions and (ii) the therapists' agency to begin and end the sessions and make therapy arrangements; and in the mode in their access to the external world, for example, by telephone (see material action below).

On the other hand, patients' talk is for the most part [QUOTIDIAN]. When patients do attempt to talk in 'specialist' language they display their lack of specialisation by their use of jargon

terms from popular psychology, for example, *personality types*, which is then dismissed by therapists.

The field of 'self', already shown as simultaneously [SPECIALISED] and [QUOTIDIAN], is particularly dependent on tenor, partly because 'self' is so embedded in relationships and partly because in the mode network it is a [constitutive] language task achieved by two interactants.[84]

2. MATERIAL ACTION

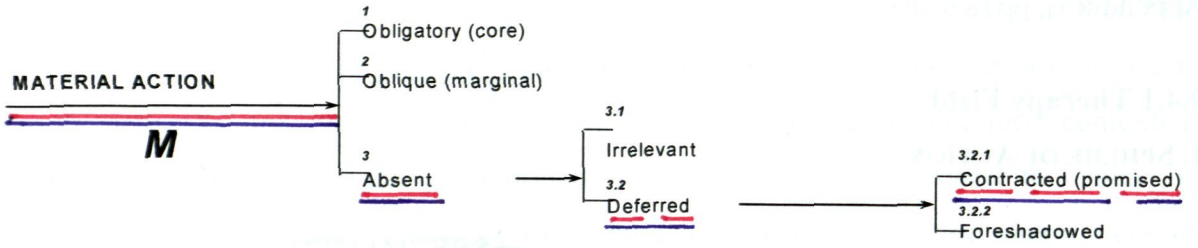

Figure 9.4 Field: MATERIAL ACTION

MATERIAL ACTION concerns the business of therapy rather than the field of self. Therapists have a wider range of potential MATERIAL ACTION than patients. Some patients, for example, Emma, have an option to listen to taped sessions, which increases their ability for metadiscussion of previous sessions. Others may keep journals or write poetry, so that the move to written language itself increases the opportunity for reflection (Meares 2005:32), although this is not observed in the SCN Corpus.

3. Action with Symbols

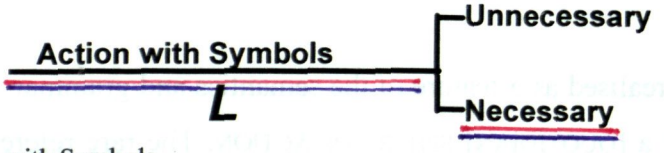

Figure 9.5 Field: Action with Symbols

For patients and therapists [Action with Symbols] is [Necessary], although therapists have the greater potential across [Action with Symbols]. Patients may develop an expanded network potential with increased time in therapy. The Action with Symbols domain of contrast is now further described for the more delicate network selections.

[84]When language is [Ancillary] to a task it can be achieved regardless of the relationship between participants, for example, stitches can be removed whether or not a patient and doctor like each other, although the better the relationship the more easily it is achieved. Presumably, it would be very difficult to create a new self with a therapist whom one did not like.

3.a) Relation Based / Reflection Based

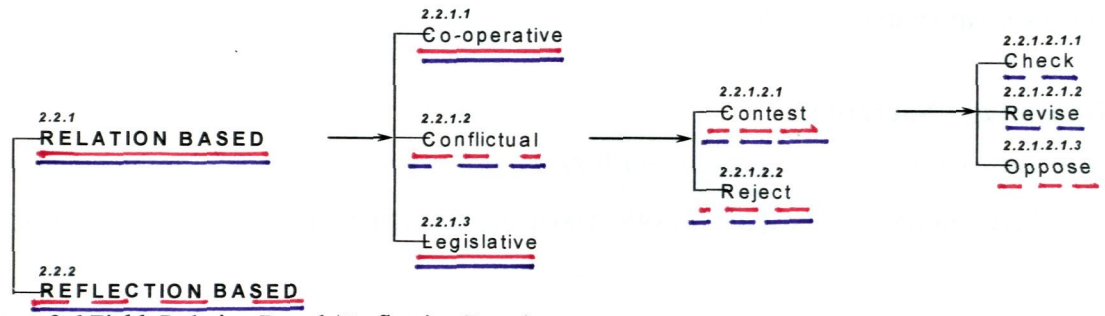

Figure 9.6 Field: Relation Based / Reflection Based

The field is predominantly [RELATION BASED]. This is textually foregrounded by patients, for example, when they show anxiety about therapists going on holidays. For therapists [RELATION BASED] aspects of therapy are essential for the creation of 'intersubjectivity' (see section 9.1). The Conversational Model also theorises the importance of the therapy relationship (Meares 2001, 2005).

Yet, for therapists, therapy is also simultaneously an experiential activity [REFLECTION BASED], since therapists are always metaparticipants in the discourse; at one level, involved in the everyday talk, and at another, using their professional training to reflect on the patient's self as 'the problem which draws on all participants directly' (Butt 2003:24, definition of [REFLECTION BASED]). Patients' [REFLECTION BASED] talk, on the other hand, is rare[85].

Overtly, in the SCN Corpus patients and therapists work in a [Co-operative] setting, with therapists working to maintain co-operation in order for therapy to continue, which of course does not disallow [Conflictual] talk. In fact, it is the background [Co-operative] context that establishes the tenor of trust for [Conflictual] talk to occur. Patients can, and do, raise issues of conflict, for example, the frequency of sessions. Thus, at some points for patients the relationship is [Contest] and [Check] /[Revise]/ [Oppose]. Therapists, while concentrating on the [Co-operative] nature of the talk, can also expand this network carefully to [Conflictual] at appropriate times in therapy but they do not [Oppose]. Thus, any changes in the delicate selections of this context network selection may suggest transition points in the creation of Scripts, Chronicles and Narratives (see section 9.9).

The contextual feature [Legislative] is not overtly discussed by the two participants; namely the therapist's rights to schedule the patient and the patient's right to report a practitioner to

[85]As noted in MATERIAL ACTION above some patients are given activities to increase their reflection based skills.

the medical review board. Given the patient's diagnosis there is a real possibility of either outcome (see Appendix B: DSM IV).

3.b) Informing / Narrating

The shift between [RELATION BASED] and [REFLECTION BASED] action is simultaneous with the move between [INFORMING] and [NARRATING] choices in a parallel domain of contrast.

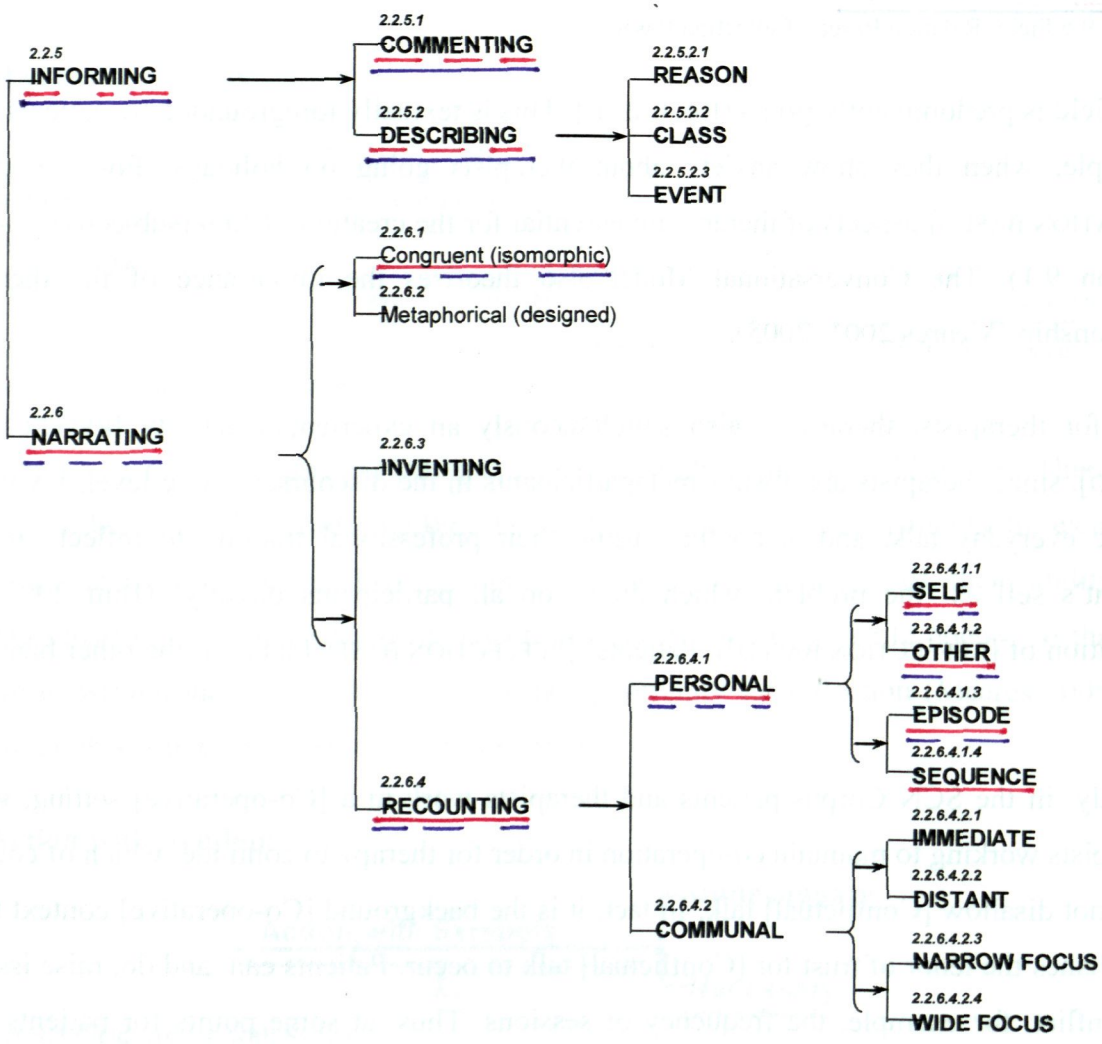

Figure 9.7 Field: Informing / Narrating

[REFLECTION BASED] and [INFORMING] are therapists' usual patterns and patients' rare patterns since for the most part they are [NARRATING] [RECOUNTING] [PERSONAL] [SELF] and [OTHER] as episodes. Therapists [Inform] about patients and patients [Relate] [NARRATE] but also [Reflect] on themselves. So, significantly, when patients choose the therapist's usual patterns of [REFLECTION BASED] and [INFORMING] language, they are learning to be their own therapists as such, thus developing a skill they can use in life outside therapy.

4. Goal Orientation

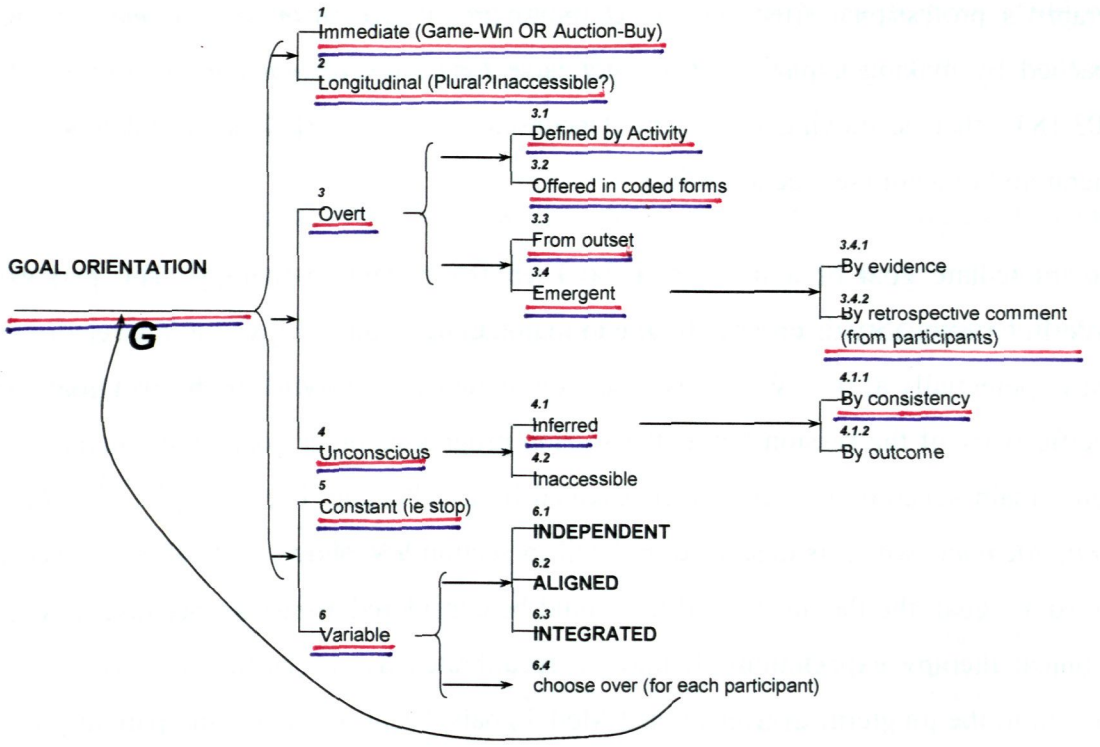

Figure 9.8 Field: Goal Orientation

Access to Goal Orientation can be difficult[86]. The goals of therapists as a 'global' context of longterm goals are explicit in their other writings to a specialised audience. These goals are set down by their own professional institution and reinforced in a therapist's own supervision sessions. But patients do not have access to the theory of therapy and the clinical goals at this level. Additionally, therapy goals are not always directly displayed in therapy language because the therapist is [SPECIALISED] and patient is [QUOTIDIAN] (see section 9.4.1). The duality of specialisation and quotidian goals is illustrated in the following quote;

> They now go into a kind of *laughing banter* they both enjoy. In a way, they are playing a game. Their behavior resembles that described by Ehrenberg (1990) and Feiner (1990) in their advocacy of "playlike" activity in therapy. It should be noted, however, that Dr. A is acting with a double-awareness throughout the exchange. He knows what he is doing. He sees his responsiveness as something like the amplification that the mother's resonance brings into conversational play. *(Meares 2001:761)*

Thus, what is laughing banter to one participant is 'amplification' to the other participant. The opacity of goal may also contribute to a more intimate tenor. If it were made overt to the patient that *a kind of laughing banter* is being conducted for professional reasons, it could

[86] There is considerable theoretical debate on the knowability of motivation of speakers, across linguistic paradigms, including Discourse Analysis, Conversation Analysis and SFL. I will follow the SFL position where Goal orientation is viewed within the text: *the speaker's goals/motives are unknowable unless they are embedded in the design of the social process. It is a continuous struggle on the part of the speaker(s) to calibrate their perceived goals with the perceived design*

break the intimate tenor. Similarly, for example, when a patient question highlights the therapist's professional friendship as commitment, do *you want to see me*?, context is breached by making explicit *matters that have long been assumed to be shared* (Moore 2003:184): that is, moving goal from [Unconscious] to [Overt]. It also makes visible the [Hierarchy] of tenor (see section 9.4.2).

The immediate goal of a therapist is to keep the patient in therapy. The person with borderline personality disorder is fragile to maintaining relationships[87], so the relationship is always potentially at risk. Within each session therapists commence with open goals for the specific work of the session but as the session progresses other goals may emerge or may even remain subconscious until later revealed by a colleague. For example, *N1: Rain and Bunny Memory*, which is described in detail in section 9.9, shows that, when viewed as an immediate goal, the therapist's self talk could be considered a mistake because it is against canonical therapy expectations. It may be recalibrated as successful, however, when re-oriented to the longterm Conversational Model goals, because it helps the patient produce a 'spontaneous' 'nonlinear' text. Thus, immediate goals are expected to change locally across Scripts, Chronicles and Narratives.

9.4.2 Therapy Tenor

1. SOCIAL HIERARCHY

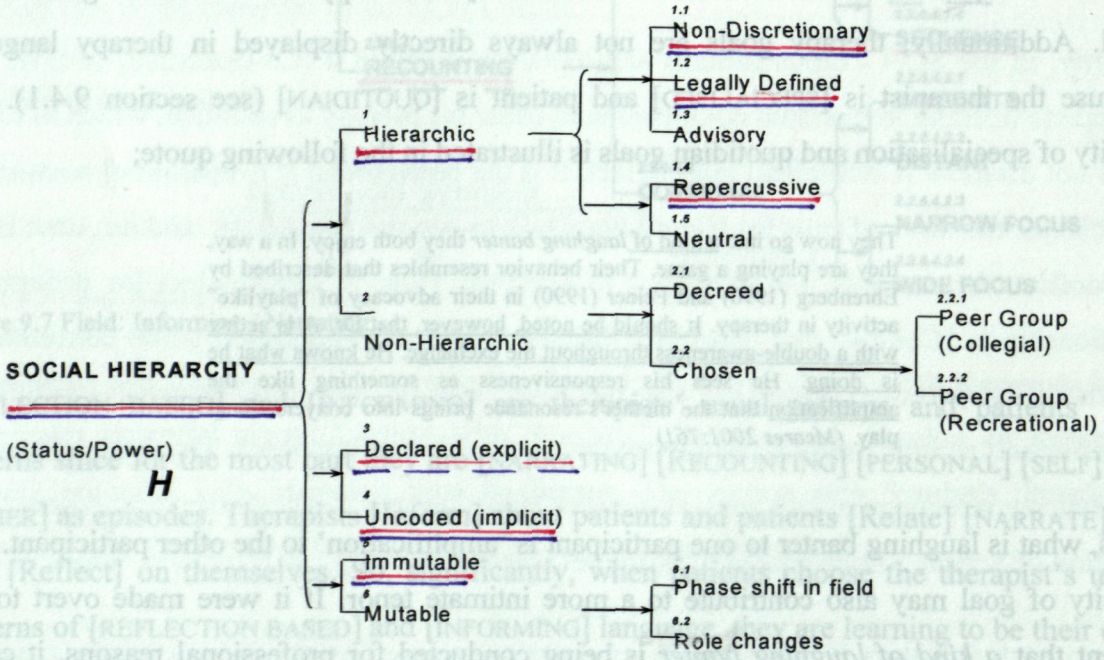

Figure 9.9 Tenor: SOCIAL HIERARCHY

of the social process so that the outcome matches the goal. (Hasan 1999:237)

[87]The DSM IV description for borderline personality disorder includes: A pattern of unstable and intense interpersonal relationships characterised by alternating extremes of idealisation and devaluation (see Appendix B).

The tenor is [Hierarchic] [Non-Discretionary] and simultaneously (rather than contrastively as drawn in the general network) [Legally defined]. The Hierarchy is [Repercussive] both interpersonally and legally, in that a patient could be scheduled for a breach of hierarchy or a doctor could be deregistered.

In order to create the intimacy required to work on self, [Hierarchy] needs to stay [Uncoded] and does so, mostly due to the [QUOTIDIAN] field. The [Hierarchy] is [Immutable] but is derived from the 'power to' rather than 'power over' to use Moore's description of power in doctor-patient relations (Moore 2003:183)[88].

2. AGENTIVE ROLE

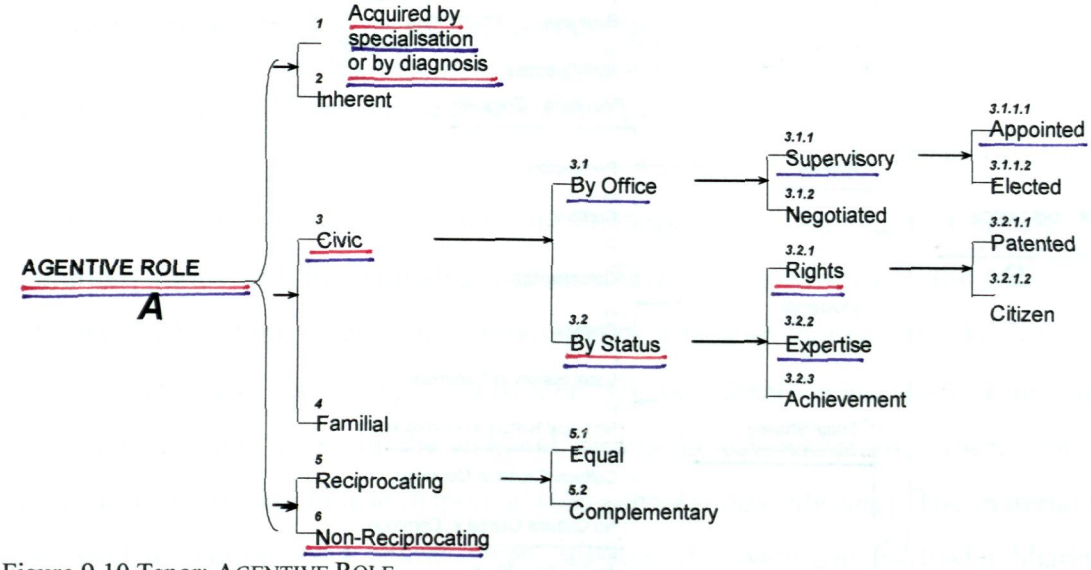

Figure 9.10 Tenor: AGENTIVE ROLE

The AGENTIVE ROLE is [Acquired] for both participants. A further degree of delicacy has been added to show that the role for the therapist is [Acquired] by [Specialisation] but for the patient by [Diagnosis], indicating the very different social values of their roles. It is clear that the 'patient' role can extend beyond therapy (as explained by P3,Clare, *it is hard to be normal when you see a doctor two to three times per week*). Further, it may even be argued that the role of mentally ill patient is [Inherent] for the patient unless mental illness is called [Negative Acquired Cultural Capital][89] (see [SOCIAL DISTANCE] below). The role of Doctor too, can carry over to external contexts, but this role has high [Cultural Capital].

The therapist role is [Civic] [By Office] [Supervisory] [Appointed] and the role is [Non-Reciprocating]. Therapists have status [Expertise] but occasionally give patients a field

[88] Power is a diffuse and multifaceted term that is not used in the context networks, because the features can be mapped more directly in the tenor domains of contrast.

[89] The question in itself raises societal hierarchical issues beyond the scope of this thesis.

based [Expertise], for example, in playing computer games [BPD Corpus: PC]. Patients have [By Status] [Rights], for example, to be treated according to Hippocratic oath.

3. SOCIAL DISTANCE

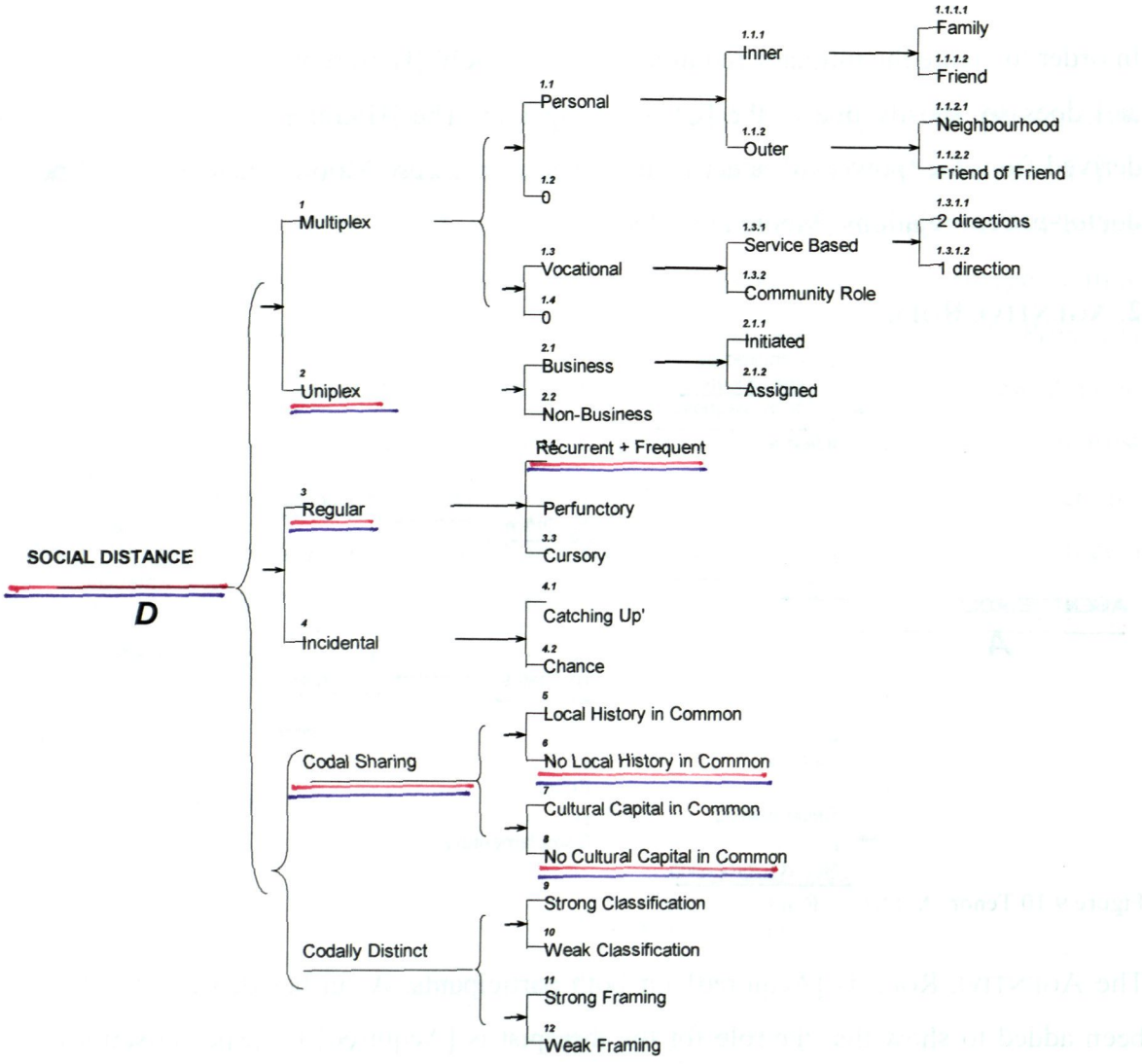

Figure 9.11 Tenor: SOCIAL DISTANCE

[SOCIAL DISTANCE] describes the relationship that allows for both intimacy and institution. The social distance is [Uniplex] and [Regular] [Recurrent] with my addition of [Frequent].

Increased [Frequent] increases the opportunity for increased [Repeat Event] and [Metadiscourse] in the field network. When patients are ill, their session frequency increases, even to daily. However, high frequency in itself has no causal relationship with intimacy. It does not always reduce [SOCIAL DISTANCE], for example, work colleagues may never become friends. Nor does it imply the converse, for example, families may have low frequency but maintain high intimacy. Frequency of therapy sessions is evaluated differently in different texts of the SCN Corpus. In one Script [Frequent] is negatively evaluated

because it is an activity associated with being 'abnormal', as cited above, *its hard to be normal when you see a doctor two or three times a week*. In contrast, Extract 9.1 below, from the wider BPD Corpus, shows a positive evaluation of therapy [Frequent].

P	Because yesterday I noticed how different I felt about coming for the extra. Like before I used to come but I was so worried about it and ringing you up was the same sort of thing. Yeh I felt different yesterday, I felt like it was safe, it was alright and it's been good coming every day.
T	Mm
P	I wasn't as hesitant today.
T	No. They do say that frequency does increase continuity when the thing's continuous.
P	Yeah
T	But also it's important to remember the fact that you don't feel that it's continuous when you only see each other twice... .
P	'cause it's too often you mean?
T	We do it more often than you see most people in your life.
P	Yes it is really isn't it? It's more often than I see my friends usually.
T	I mean there's a difference going on here I don't want to -

Extract 9.1[FA turns 93-102]

Codal sharing is [No Local History in Common]. The degree of [Cultural Capital in Common] varies with the individual patient. There may be some potential for more delicate networks of [Cultural Capital in Common] here, which are not necessarily directly derived from the language, for example educational levels[90], employment (only some patients are able to work) and even in the material setting of psychotherapy, where, for example, classical art works could also display a wide gap in [Codal Sharing]. The material setting is discussed in section 9.4.4 below. Overt displays of a wide gap in [Codal Sharing] could increase the patient's sense of social inadequacy.

Instead of [Codal Sharing], which is largely unchangeable, in this context it may be more appropriate to map [Therapy History] independent of [Frequency], since [Frequency] can be positive or negative, as discussed above. The longer the [Therapy History], the increased number of incidents available for [Metadiscourse] or [Repetition], which allows for a change in social distance: a seeming increase in intimacy as more of the self is revealed (within the overarching contextual constraints) and a shared [Therapy History] to draw upon. It is seen in the lexicogrammar and the semantics textually as a second entry to topics, for example, *remember I told you, well you know how mum wants* ... [BA turn 141].

Affectual stance is not directly mapped in the context networks. It can be argued that Affect is dispersed across other strata, in lexis (in the lexicogrammatical stratum) and semantics.

[90] One patient is a high achieving tertiary educated person who would presumably share some [Cultural Capital in Common] with the highly tertiary educated therapist.