GROUNDED THEORY REVIEW
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# Grounded Therapy[1]

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My introduction to grounded theory occurred in 1967, when Barney G. Glaser and Anselm L. Strauss published *The Discovery of Grounded Theory,* the seminal statement on grounded theory. At the time, I was an undergraduate student in sociology. The book made a deep and lasting impression on me. I determined that I wanted to learn "how to do that." I was given this opportunity in 1970, upon my admission to the Graduate Program in Sociology at the University of California, San Francisco. In addition to other fine faculty members, this program was home to both Barney Glaser and Anselm Strauss. Thus, I was able to learn grounded theory, from the ground up, so to speak, from its originators.

My introduction to therapy[2] occurred during the course of my dissertation research (Bigus, 1974)[3]. The topic of this research was what I came to refer to as "the alcoholic career." I used a qualitative, grounded theory approach, collecting my data through a combination of intensive interviews and participant observation field research. During this research I had the opportunity to observe therapy sessions between alcoholism counselors and their clients, in inpatient settings. At the end of many of these sessions I was able to interview both the client and the therapist, for their impressions and interpretations as to what occurred during the sessions. The disparity of views between the two parties impressed me. In general, the therapists tended to have a much more positive view of what occurred during the sessions than the clients did. The

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therapists tended to believe that some positive ground was made during the sessions, whereas the clients tended to express varying levels of disappointment and anger about the sessions. This was certainly not always the case, but it was often enough 'the case, at least in my mind, to point to problems in the therapeutic relationship and approach. Although these issues were not the primary subjects of my research, I couldn't help but take notice of them, out of strong personal curiosity.

In subsequent years, through teaching and consulting work, I had further opportunities to observe and reflect upon the therapeutic relationship and process. Eventually, I became a therapist, myself. Since then, I have had an abundance of opportunities to not only make such observations, but to participate in therapeutic relationships, and the therapeutic process.

From the beginning of my experience with therapy, I saw many areas in which it was evident to me that the therapeutic process and the therapeutic relationship could be improved. As I learned more about grounded theory, it also became evident to me that grounded theory might be very useful in this application. Some years later when I became a practicing therapist, I was able to empirically test this supposition. My original hunch has proven to be solidly correct. One of the original promises of grounded theory, "to be usable in practical applications" (Glaser and Strauss, 1967: p.3), has certainly been fulfilled, in this instance.

In fact, this promise has been fulfilled in a way which was evidently not originally perceived. The original thought appears to have been that with grounded theories, "prediction and explanation should be able to give the practitioner some understanding and control of situations" (Glaser and Strauss, 1967: p.3). What I have discovered is that the grounded theory process itself (not just grounded theories) is very useful as a model for guiding a grounded therapeutic process albeit in a modified form to fit the situation. Because of the inherent nature

of this relationship, I refer to this approach as "grounded therapy." Grounded therapy is a methodology by which to achieve therapy.

Because of the requirements and limitations of this format, i.e., a chapter in an anthology, I have limited the breadth and depth of my discussion.[4] My purpose here is not to present a detailed exposition of how to conduct grounded therapy, but merely to present enough of an outline to give the reader an idea as to what sorts of problems it addresses, how it addresses them, and how it proposes to solve them. And, in the course of these tasks, I hope to illustrate a practical application of grounded theory. The intended audience of this book is primarily sociologists interested in grounded theory, not therapists, so to avoid unnecessary digression, I shall assume readers have more than a passing familiarity with grounded theory.

## Approaches to Therapy

Therapy consists of two general, interrelated components – the "explanatory" (to identify, understand, explain) and the "operative" (to solve, remedy, rectify, heal). In my experience, grounded theory, in modified form as grounded therapy, is useful in the service of both tasks.

A plethora of therapeutic theories, models and paradigms exist for therapists to use. Some are formulated for use in specific substantive areas, and some for more general application. Each consists of some configuration of explanations, concepts, understandings, assumptions, operational prescriptions, proscriptions, and so forth, which if followed promise results. Unfortunately, research on the effectiveness of therapy suggests that often it does not produce the desired results, at least as practiced.[5] It is this problem which I am attempting to address here.[6]

I might add that in this context, I am much more interested in what I have observed therapists actually saying and doing, in practice, rather than what is contained in the literature, as the literature becomes "real" only through its empirical use.

Many therapeutic models are configured as a set of precepts, which some practitioners, usually the novice and less creative ones, use essentially as "formulas." With this approach, the therapist attempts to "stay within the lines," of whatever procedural dictates are espoused by the particular therapeutic model(s) they are using. This general approach to therapy might be referred to as 'formula therapy." The essential problem with a formula therapy approach, is that it lacks the flexibility required by an applied enterprise. In therapy, each new situation requires a fresh, yet informed start. However, formula therapy proceeds in an essentially deductive, rather than inductive manner. And, if any enterprise cries out for an inductive, "discovery" approach, it is therapy.

Another, somewhat opposite approach to therapy is what might be referred to as "improvisational therapy." Some therapists attempt to free themselves from formulas by pulling what is useful in a given circumstance from their "menu" of known theories, concepts, approaches, and such, conducting therapy in an extemporaneous manner.[7] With this approach, therapists make up the rules as they go along, so to speak. They pick and choose whichever explanatory or operational construct appeals to them at the moment. This process may be somewhat more inductive and creative than a formula therapy approach, but it may also be uninformed and erratic. In using this procedure, therapists have to rely primarily on their own creative sensibilities. Furthermore, once they have selected a particular therapeutic mode, they may resort to applying it in a formula manner.

What is needed are systematic, yet flexible guidelines with which to avoid the inflexibility of formula therapy and the capriciousness of improvisational therapy. I believe grounded therapy can provide this, by giving "permission" to be creative and by providing a systematic and informed means by which to do it. To demonstrate this, I shall outline what I

think are the prominent problems of therapy, as I have seen it practiced, and how these problems may be minimized through the use of a grounded therapy approach.

## Preconception

One of the primary problems with the way therapy is ordinarily conducted is that it is predicated on a number of a priori assumptions and preconceptions, most of which are unnecessary, and detrimental to the therapeutic process. These preconceptions are detrimental, not only because they have not "earned" their position of primacy, but because many of them are epistemologically and empirically questionable to begin with. This detriment occurs not only to the process of developing explanations for the issues under question, but for the curative process which therapy is presumably all about.

These a priori assumptions and preconceptions consist of concepts, frameworks, models, paradigms, procedures, and so forth, which are presumed to be relevant and useful, without question, nor without having systematically earned their way into relevance. From my observations, the following are the most damaging a priori assumptions routinely made by therapists:

1) One a priori assumption which appears to be almost universally held by therapists is a belief in the notion of "unconscious" (or subconscious") mind. In all the years I have been around the therapy professions, I have seldom heard practitioners (as distinguished from theorists) of therapy seriously question (or for that matter even discuss) this concept. This is made particularly problematic by the way in which I have seen the concept used. It is generally used in such a way as to indicate a belief that there resides somewhere in the human brain a *pro-active* unconscious mind, which is not only capable of, but frequently does "overrule" and even "trick" the conscious mind. The unconscious mind is often given primacy over the conscious

mind in explaining, particularly problematic behavior, thoughts, and emotions. However, the existence of a pro-active unconscious mind can only be "known" through inference. In my observations of therapists searching for explanations, this often results in remarkable inferential leaps, in which more obvious variables are ignored in favor of this "hidden" concept. To do this is to treat an empirically unprovable abstraction as more real than that which *is* real (i.e., conscious thought).[8]

The notion of (pro-active) unconscious mind is also often given primacy in the curative (as opposed to explanatory) side of therapy. This results in the use of "indirect" techniques, which are used to presumably "bypass" the conscious mind. This produces a form of "mysteriousness" which may alienate the client from the therapeutic process. The therapist presumably knows what is going on, but the client may not. If the client does "see through" what the therapist is attempting, they may be insulted, annoyed, or in some other way "put off" by the thinly veiled attempt to do something *to* them, rather than *with* them.

I see much less of a problem with the notion of unconscious if it is used as an adjective, to refer to "unconscious mental process" or "below the level of awareness," rather than as a noun, "with connotations of a definite region, a dark and forbidding territory to be apprehensively but courageously explored" (Thornton, p. 254). However, to assume that the unconscious can be conscious and unconscious simultaneously, is oxymoronic.

2) A second a priori assumption, very much related to the concept of unconscious mind, consists of a belief in the primacy of emotions in explaining thought and behavior. It is all too often assumed that the basis of the client's problem is to be found in some aberrant emotional state, usually stemming from problematic early childhood or "family of origin" experiences. Again, there is a tendency to "leap over" more obvious explanations in favor of the less obvious.

Psychotherapy may be more glamorous for the therapist, but it is not necessarily what the client needs. As with any other variable, emotional variables must "earn" their way into an explanation.

In the same vein, "systems theorists" sometimes give the same level of primacy to "the system," usually the "family system," as a casual variable. The problem lies not so much in the concept of system, as m the a priori assumption that "the system" is the determining variable. However, if the notion of system is regarded more as an "entity" (common with systems theorists) than as an abstraction which represents a set of dynamic relationships, this presents the problem of reification.

3) Another a priori assumption, also very much related to the concept of unconscious mind, is the notion of "pathology."[9] It is often, in fact in my observation, usually invoked in such a way that some aspect of the client is viewed as pathological. The most common version of this is found in the use of the medical model, wherein clients (referred to as "patients" are "diagnosed" from the DSM-III-R,[10] as having some sort of a "disorder," which is then "treated." Simply because a person's emotions, thoughts and/or behavior may be problematic for them or others, it does not necessarily follow that some feature of their person is pathological.

In my own practice, I have not once found it necessary, or even useful, to "pathologize" a client, although I have had numerous clients who had previously been pathologized by former therapists. One of the first things I have done with these clients is to "de-pathologize" them.

Even though I frequently have heard therapists condemn labeling and pathologizing, they nonetheless frequently do it. I have heard much mention of "wellness models," but in practice the same therapists often insidiously, and seemingly without awareness, use the notion of pathology. Furthermore, a wellness model presents most of the problems of a pathology model, because it is

still a formula full of inherent preconceptions and a priori assumptions. The problem is not just in pathologizing, it is in preconceiving. This is one of the problems that grounded therapy is designed to overcome.

However, regardless of awareness and intent, this concept can be very damaging to the therapeutic process, the therapeutic relationship, and to the client. Probably the most damaging aspect of a pathologizing label is what it can do to the client's own self-concept. The client may come to see themselves as "a co-dependent," "a manic-depressive," a "depressed person," "an enabler," ad nauseam. They may come to see themselves as being "possessed" of an "affliction," over which they may have little or no power (especially without the help of the therapist). This may become the dominant factor in their own self concept, and even the inundating focus of their lives. This can be a very "disempowering" experience.

On the other hand, if the client has reservations about being pathologized, they run the risk of being further pathologized through the therapist invoking such concepts as "resistance," "denial," or even "oppositional disorder." In my experience, however, if and when these phenomena exist, they are most often an artifact of the therapeutic approach, particularly as a response to the experience of being pathologized.

The pathology notion presents a myriad of other problems in the therapeutic process and relationship, which, because of space limitations, cannot be delved into here. Combined, the above three a priori assumptions (unconscious mind, primacy of emotions, and pathology) present a mountain of difficulties for therapy, as they are usually invoked in concert with one another. In the present venue I am able to only give a brief indication of the types of problems they present.

In addition to the above a priori assumptions, a number of other sources of preconception are endemic to therapy as it is practiced. The most common of these are as follows:

1) Preconception in the therapeutic process usually begins immediately, through the collection of "intake information." Agencies usually require that their therapists complete intake forms on each new client. These forms usually contain "face sheet" types of information, which is preconceived to be of use in the therapeutic process, such as gender, age, income, religious affiliation, race, ethnicity, marital status, parental status, number and ages of children, alcohol an drug use patterns, health status, previous therapy, family of origin material such as birth order, number and gender of siblings, family alcohol and drug use patterns, and so on. Many agencies provide additional forms, which cover more topics m more detail, to be used as a "tool," at the therapist's discretion. Many therapists in private practice also collect such intake information, often using forms identical or similar ·to those which they have been provided by current or former agency employers (many therapists combine agency with part-time private practice).

In therapy, preconception is simply not viewed as a problem. In effect, it is more often seen as a preference, the assumption apparently being that the more information you have to guide you from the outset, the better.

2) One of the most notable forms of preconception in therapy is what is usually, referred to as "the treatment plan." The treatment plan is comprised of preconceived ideas regarding what constitutes. "the problem" (or "issue"), as well a what approaches the therapist will take in addressing it. In agencies, the treatment plan is ordinarily part of the intake procedure. The therapist is required to preconceive both the explanatory and operative sides of the therapeutic. process, before they have information beyond that collected during the intake process, which

itself is preconceived. Although the therapist may alter or ignore this plan as therapy evolves, it may have already done its damage, having served as the foundation for the therapeutic process.

3) Another source of preconception in therapy is an outgrowth of the use of the medical model as it is applied to behavior, thoughts and emotions. Many agencies require their therapists to advance a DSM-III-R diagnosis, either as part of the intake procedure, or for the purpose of third party payment (as a virtually universal requirement of medical insurance companies). Although it is not uncommon for therapists to at least attempt to disregard the diagnosis, just the fact that so early on in the process they are required to frame whatever information about the client they have may present in insidious preconception. They are forced to think about the client and their situation, issues, problems, etc. within the medical model framework, to arrive at a diagnosis that has some semblance of fit.[11] Once this pseudo-analytical process has begun, it may be difficult to completely "erase" the diagnostic framework, particularly for therapists who have little training and experience in analysis (of which there are many). Because they are essential components of the medical model as it is used in therapy, therapists may begin to invoke the a priori assumptions discussed previously (the primacy of emotions, the unconscious mind and the notion of pathology), while consciously rejecting the specific diagnostic label. Although many therapists are inclined to invoke these assumptions regardless, advancing a diagnosis can only reinforce these a priori assumptions, and lend them a sense of legitimacy.

4) Another source of preconception in therapy occurs through the use of psychological tests. Such tests are sometimes given as part of the intake procedure, or early in the therapeutic process. The information derived from psychological tests is presumed to have value in identifying problems and/or providing a "psychological profile" of the client. This once again presents the problems of assuming unearned relevancy.

Most psychological tests classify test takers into "types" (which may or may not impute pathology),[12] provide diagnoses, or assign a score on a scale. With each of these alternatives, all of the problematic implications of a label are brought into play. The client may begin to incorporate the label into their own self-concept, coming to believe that they "are" the label. This presents the risk of the client permanentizing their problem or issue as an endemic part of their self, rather than a phase in their life, or a stage in a process. Moreover, the therapist (and the client) will likely see the test results as verified "fact." The illusion is created that the labeling process is removed from the realm of subjective judgment, and placed into the realm of objective science. Furthermore, the therapist may begin to essentially "treat" the label rather than the person.

5) Like most other cultures, the therapeutic culture experiences its share of fads. This gives rise to another source of preconception in therapy. Diagnostic categories, labels, concepts, models, and so forth (for the sake of brevity I shall refer to them as "explanatory/therapeutic constructs") tend to change over time, sometimes from new knowledge, but more often out of the cultural tendency towards fads. A once popular construct may be replaced by another somewhat analogous or overlapping construct. Some explanatory/therapeutic constructs remain rather stable (e.g., the medical model of alcoholism)'. but others change frequently. For example, at one time a client may be viewed as an enabler, at another time they may be viewed as a "co-dependent." This is not to say that these constructs are absolutely interchangeable. They are not. They are, however, similar enough that at onetime in the cultural history of the therapy professions there may be a tendency to see ~hents through "enabler (or whatever) colored glasses," and at another time a tendency to see them through "co-dependency colored glasses." One construct may have no more or less explanatory or therapeutic value than the other, but like

with all fads, its users eventually become bored and weary of its imagery, and seize another as it comes along, primarily because of _its freshness. This lends a certain capriciousness to the enterprise: And, hake all fads there is a tendency towards overuse when the fad is popular. With explanatory/therapeutic constructs, this exacerbates the tendency towards preconception.

If the conceptual and theoretical side of therapy were better ~rounded, this would be less likely to occur. Grounded concepts and theories can be moved over time and space. This is one of their strong features. However, because they are grounded, they are much less likely to employed with such arbitrariness. Ungrounded concepts can too easily become "free floating."

6) Therapists, like all persons, have a tendency to become comfortable with the familiar. This engenders another source of preconception in therapy. When contemplating new information, therapists tend to limit their search for explanatory/therapeutic constructs to those which are available, familiar and comfortable.

A particularly insidious source of preconception occurs in the way in which "the problem" itself is defined. Is a client s essential or core problem "low self-esteem," "depression, " " anger, " " grief," "sub stance abuse," or a "dysfunctional relationship?" Frequently, all of these (and more) are present in the lives of one particular client. How is the therapist to resolve which is the "real" problem? Is "anger" a property of "low self esteem," or is "low self esteem" a property of "anger?" Is "substance abuse" a property of "depression," or is "depression" a property of "substance abuse?" Each of these "problems" has overlapping indicators. So, what is an indicator of which? Should the therapist accept the client's definition of "their problem"? What if the client's definition has only tenuous fit with the circumstances? For example, it is not uncommon for clients to "discover" or define "their problem" through reading self-help literature or from talking with friends who have or are currently undergoing therapy.

Therapists are seldom trained at analyzing, generating and synthesizing theoretical constructs. Thus, they have only those with which they are already familiar to choose from. This familiarity usually comes with their training, in graduate school and from courses and workshops subsequent to graduate school. With experience, they may become so comfortable with particular ways of viewing and doing things that it becomes taken for granted. It no longer occurs to them that it may be productive to question their perspectives, assumptions, methods, and so forth. Once therapists routinely use and become familiar with a particular set of explanatory/ therapeutic constructs, it becomes easy for them to begin to force fit them, with no awareness that they are doing so. Their application becomes routine.

In its most extreme expression, this produces a fixation with a particular pet explanation or approach. This is most likely to occur if a therapist comes to identify closely with a particular explanation or approach from their own therapeutic experience, as a client (many therapists have themselves been in or are currently in therapy), or if they become enamored with a particular explanation, approach, or theorist/therapist, from graduate school, workshops, or readings. It is somewhat ironic that such a fixation may be regarded as a "specialty," because to "specialize" in this manner is tantamount to specializing in preconception.

## The Therapeutic Culture

Part of the problem with therapy exists in the concepts, models and paradigms themselves, and part exists in the way in which they · are employed. Many of the concepts, models and paradigms are simply not well grounded in the meaningful experiences and subjective interpretations and understandings of the client. The perspective of the therapist is often given primacy over the perspective of the client. Indeed, if they are inconsistent, the client's

perspective may even be regarded as part and parcel of the problem, through such concepts as "resistance," "denial," "transference," or even "oppositional disorder."

In actuality, the perspectives and interpretations of therapists are grounded in the therapeutic subculture. They make sense to therapists because they are immersed in them during their training and in daily interactions with their colleagues. They take on a semblance of validity and legitimacy primarily through a general social consensus. Most therapy training programs include a requirement that initiates undergo some sort of psychotherapeutic experience themselves. The assumption appears to be that this experience will weed out those who do not possess the personal qualities conducive to being a therapist, and help prepare the remainder for their future role -- sort of an emotional/psychological "boot camp," as it were.

The training process in toto serves as a socialization experience, in which the initiates become members of the therapeutic "community" or "world."[13] Through this process they become familiar with the knowledge, ways of thinking, feeling, understanding, acting, interacting, and so forth of that culture. What was once generally foreign to them becomes comfortable and taken for granted, in the same manner that the knowledge, ways of thinking, feeling, etc. of any culture become taken for granted by its members. Many therapists lose touch with the_ fact that clients are not members of this culture, although some clients are somewhat familiar with it, through having read self-help literature, and through conversations with others who have been or are currently in therapy. Such clients are often familiar and comfortable enough with therapeutic jargon and such to in effect become "auxiliary members," so to speak. However, many other clients (in my experience men more so than women) find much of what they are subjected to when they enter the therapeutic milieu to be some combination of uncomfortable, insulting, confusing, intimidating, and sometimes even ridiculous and silly, and

generally foreign. They seldom express this to their therapist. Some simply leave. Some feel inadequate and blame themselves for their inability to understand and relate to it. Some learn to tolerate it. Some eventually become more comfortable with it, and are "converted."

However, many clients find that the meanings which they derived from their experience in the therapeutic milieu are of limited value in their real lives. When they are themselves active participants in the therapeutic milieu, its meanings possess an appealing veracity. However, when the leave the aura of this setting and the therapeutic relationship, what they have learned is often less useful than it first appeared. Outside this setting much of what they learned is simply not realistic. Without the weight of the therapist's countenance, these new meanings begin to lose their magic. Unfortunately, many clients see this as their own shortcoming, rather than the therapist's. Others lose faith in the idea of therapy.

This is not to suggest that what they have learned is of no value. It is to suggest that if what clients learned in therapy was more completely grounded in their own experience and meanings, they would benefit a great deal more. I would also point out that many clients are helped a great deal by their therapeutic experience, often more by the relationship itself than by the particular therapeutic mode. And, of course, sometimes there is a gainful fit between a particular therapeutic approach and a particular client.

## The Therapeutic Relationship

A third problematic area in therapy occurs within the therapeutic relationship. It has often been stated, probably correctly, that therapy *is* the relationship. To the extent that this is true, it is extremely important that the formation of a therapeutic relationship be accomplished carefully and with consideration to its therapeutic consequences, risks and opportunities. The evolving

therapeutic relationship becomes the foundation for the therapeutic process. In fact, the relationship and therapy evolve in an interweaving manner.

In the more than twenty years since I was first introduced to them, I have seized many opportunities to conduct extemporaneous interviews with people who have been on the client side of therapeutic relationships. Never having been a client myself, I have always been most interested in understanding the phenomenological experience of being a client, so my questions have been primarily along these lines.

In terms of the effectiveness of the relationship (the outcome), responses have ranged widely from, "it saved my life," to "it was a complete waste of time and money," to "it made matters worse." In terms of overall satisfaction with the relationship itself, responses have ranged from "it was the best relationship I have ever had," to "it was awful." Although I made no attempts to construct a representative sample (understanding, not generalization, has been my goal), I have received a distressing number of negative responses to my queries about the experience and effectiveness of these relationships.

In the many extemporaneous interviews I conducted, the experience of being on the client side of a therapeutic relationship was often described in less than glowing terms. The following is a list (in no particular order) of the negative words and terms most often mentioned in these interviews (in some instances I have used my own summary terms): feeling disrespected; feeling deceived; being the object of suspicion; feeling mistrusted; feeling blamed; feeling "analyzed" (the feeling of "being under a microscope"); feeling judged, particularly feeling unfairly judged; feeling misunderstood; feeling confused; not knowing what's going on (i.e., feeling mystified); feeling alienated; feeling inferior; receiving no feedback; feeling or being treated passively; not feeling listened to; being treated as an "object"; being treated as if you were "sick" (i.e., feeling

pathologized); being treated with indifference; feeling patronized; being neutralized; being invalidated; being disapproved of; having no "boundary rights"; having no rights of grievance; being treated with impatience; being treated as stupid or unaware; not being talked to "directly" (i.e., "beating around the bush"); being asked or "forced" to act in unnatural or affected ways (e.g., talking to an empty chair).

Unfortunately, very few persons I interviewed informed or complained to their therapists regarding these matters. As a result, the therapists were probably left with the impression that "everything is okay." Once again, this was often the case in the instances in which I observed therapy sessions and subsequently interviewed the participants.

The reluctance of clients to complain to their therapists is probably related to the fact that therapeutic relationships are characterized by inherent status differential, to wit, that of "doctor/patient," "helper/ helped," "expert/layman," and the like. We all have experienced relationships, even intimate ones, which are characterized by status differential. Most of us are generally comfortable with this, particularly if the relationships are personally rewarding (e.g., parent/child, student/teacher, and coaching relationships). So, the status differential inherent in therapeutic relationships is not necessarily problematic. However, it can become so in at least two ways.

First of all, it may become problematic if the client accepts status asymmetry and gives over autonomy to the therapist. In such instances the client tends to defer to the therapist's "authority" and " expertise,"' and accepts. what the therapist says, does, or suggests, often blaming themselves if it is ineffective. Some clients initially give a valiant try at maintaining generally equal relationship, but eventually succumb to the might of the therapist´s authority. Others give over their autonomy from the beginning.

Secondly, it may become problematic for some clients if they feel uncomfortable with being on the "lower" side of status asymmetry. In therapy, this often takes the form of the client not wanting to feel as if the therapist has power over them (e.g., the power to ask personal questions, the power to make judgments about them, the power to degrade them or in the case of relationship therapy, the power to affect the balance of power the relationship).[14]

In the instances, the client may resist the perceived power asymmetry, which will likely present a myriad of problems in the relationship, such as lack of trust, lack of respect, uncooperativeness and so forth This may in turn result in the therapist seeing this resistance as in inherent, problematic feature of the client's personality, language of emotions and so on, and therefore a property of "the problem" or "the disorder." Such labels as "resistance", "denial" or " transference" may then be invoked. Of course, this will only compound the problem. It is ironic that although. The problems may be an artifact of the therapist's approach, the client is essentially held responsible. This may leave the client feeling, "blamed."

## Grounded Therapy

I have sketched the problematic areas in therapy -- preconception the therapeutic culture, and the therapeutic relationship. The problems in these three areas cannot be understood in isolation from one another, as they are very much interrelated. The therapeutic culture effectively serves as global preconception. It provides the explanatory and operative frameworks within which therapists practice their profession. It also provides the everyday understanding, prescriptions and proscriptions -- ways of thinking, acting, interacting and so forth -- which are inherent to culture. It is these factors, any combined, which "drive" therapy and the therapeutic relationship. How then should one construct a satisfactory therapeutic relationship and process?

In my view, the best way to accomplish this is to take a grounded approach, by enlisting the following guidelines:

1) *Begin with as few preconceptions about the client and their situation and as few theoretical preconceptions (both explanatory and operative) as possible.*[15]

Glaser and Strauss (1967: p.5) assert that the adequacy of a theory cannot be divorced from the process by which it is generated. I believe the same logic holds true for therapy. Collecting information, defining "the problem," drawing conclusions, and preselecting concepts, theories, and models *before* the therapeutic process, rather than *through* the therapeutic process, may limit, misdirect, or derail therapy. With this approach, it becomes all too easy to slip into the use of "processing stereotypes," (Hawkins and Tiedemen, 1975: p.184) and to view the client, their situation, and problem as an instance of something which is already familiar, and then to take a premature "leap forward" in the process, similar to what Lofland (1970/1971) refers to as "analytic interruptus."

Furthermore, the *process* of collecting and analyzing "data" has great therapeutic potential. It should not, in fact cannot, be separated from the operative side of the therapeutic process. One of the most therapeutic of all experiences is to feel *listened to* and *understood.* If the abstract, conceptualized understandings which evolve out of the therapeutic process are grounded in the client's subjective experience, interpretations, understandings, and meaning system, and are achieved in *partnership* with the client, a large part of therapy will already have been achieved.

Questions asked on. intake forms and psychological tests are typically based' on preconceived notions about what sorts of explanatory variables are relevant. "Findings" are of course always shaped by questions. Therefore, in order for the therapeutic process to remain

grounded, not only the answers, but the *questions* must *earn* their way. Their relevancy should be *discovered* through the analytical process. This is not to say that factors which are commonly presumed to be relevant, such as family or origin experiences, cannot be relevant. They certainly can. But, the therapist should not assume their relevancy from the outset, but instead should *remain open to discovery.*

In using a grounded therapy approach, the therapist begins from a framework of presumed ignorance about explanations, solutions, the client, their situation, their problem, and so forth, then proceeds with a primarily *inductive* process, with the full participation of the client. In this manner the therapeutic process becomes one of *partnership* and *mutual discovery:* in which both therapist and client learn what is relevant and what works.

Another reason to proceed with an attitude of presumed ignorance, is that clients are usually very eager, even impatient, to "tell their story." If the therapist frustrates this urge by immediately administering psychological tests, asking long lists of questions which the client may at this point not see as relevant (even though they may be), and offering "explanations" right from the start, the client may become alienated from the process. This may encourage them to shut down, and become passive recipients of therapy, rather than active, mutual participants. Or, they may feel as if the therapist is not listening and not really concerned with what they think and feel. This may provoke them to seek another therapist, or cease therapy, altogether.

2) *Ground the frame the therapeutic process and relationship within the client's values, subjective understandings, interpretations, and meaning system.*

I once heard a psychiatrist assert, "if your client feels good when they leave a session, you have failed them." I have observed this sentiment to be fairly common in the therapeutic culture, although certainly not universal. In talking and listening to therapists who share this

sentiment, it is evident that their assertion is that change and growth are always uncomfortable, even painful, and thus if you are helping the client to feel better you are not tapping into the "real" issues, and therefore are not doing real therapy. The assumption here is that helping clients to consciously think and feel better about themselves and their lives is superficial, because the "real stuff" occurs in the *unconscious.* Another assumption often made here is that clients typically resist attempts to "break through their defenses," even though they may be unaware of it (evidently the unconscious is a "trickster"). Thus, when the therapist attempts to breach these defenses to get at the real pathology, it produces resistance and discomfort in the client.

This approach might aptly be termed "nutcracker therapy." The nutcracker approach focuses on the negative -- i.e., "breaking through" defenses so as to defeat the "pathology" rooted in the unconscious. In my experience, not only is this approach unnecessary, it is very limiting, and often even counter-therapeutic. I believe this approach, more than any other, is apt to generate the kinds of negative responses which I outlined earlier.

The nutcracker approach overlooks what I, and many other therapists who prefer a "cognitive" approach, believe is the most important asset in therapy, the resources of the conscious, subjective self. In my experience, it is most productive in therapy to work on the positive, by reinforcing and enhancing the efficacious resources of the conscious self. Furthermore, in my view, the nutcracker approach is disrespectful and insulting to clients, as it treats them as "objects" of therapy, whose subjective interpretations, and so forth must be regarded with suspicion (one must beware of "the trickster"), rather than as trustworthy, fully participating, equal partners.

In using a grounded therapy approach, from the outset the therapist seeks "verstehen," or what Rogers (1959 and elsewhere) refers to as "empathetic understanding," by attending closely

to the client's *own* subjective view of themselves, their situation, and their problem. In effect, the grounded therapist attempts to "become the other," to the extent this is possible. To have any real, lasting power for the client, the knowledge derived from the therapeutic process must be relevant to the client's everyday life, values and meaning framework.

With a grounded therapy approach, the client's values, knowledge, interpretations, understandings, and meaning system are viewed as central to therapy, and *more* important than the therapist's, as they are what guides both the explanatory and operative components of therapy. This is not to say that the client will necessarily have a fully informed and well articulated view. If they did, they probably wouldn't be seeking the services of a therapist. However, the client will always know the conditions of their life, their values, their experiences, thoughts, feelings, etc. in more immaculate detail than the therapist. The therapist's knowledge, which is more abstract, is initially secondary. As suggested above, to start, therapists should attempt to "suspend" their knowledge, so as to minimize the risk of preconception.

However, the therapist enters the situation with unique and valuable *skills* not possessed by the client. The therapeutic process involves combining the client's knowledge with primarily the therapist's skills, and only secondarily their knowledge, from whence evolves new, hopefully better conceptualized and organized, knowledge (and skills). Knowledge should be abstracted *from* the therapeutic process, not imposed upon it. To be sure, the therapist brings useful knowledge to the process. The therapist enters with abstractions, awareness, and understanding of broader patterns, processes, conditions, and so forth. But, this pre-existing knowledge should be used merely to sensitize the process, not determine it.

3) *Model the therapeutic relationship after the positive features of functional, healthy, native relationships.*

In my efforts to understand the differences between a productive versus unproductive therapeutic relationship, I have come to the clear conclusion that the contrast lies in where the relationship is grounded. Satisfactory therapeutic relationships resemble satisfactory, "native" (i.e., "real world") relationships. It is important to model therapeutic relationships after relationships in the native culture, not the therapeutic culture.

Clearly, therapeutic relationships cannot, nor should they, be exactly of the same nature as native relationships. They are artificially contrived for a specific purpose, so they should include only those components of native relationships which are productive for this purpose. Native relationships, even the best of them, are sometimes characterized by conflict, judgmentalness, impatience, and so forth. Insofar as it is possible, these features of native relationships should not be duplicated.

Therapeutic relationships are, probably more often than not, modeled after "doctor/patient," or "expert/layman," and such, relationships. The therapist is viewed as already possessing the special knowledge which the client needs. The client's knowledge is typically viewed as being secondary, even irrelevant or counter-productive. The therapist is viewed as the "authority," or "expert," the client as the "layman," The therapist is viewed as "the helper," the client as "the helped." Although these things may be essentially true, they do not need to comprise the framework within which the relationship is conducted. Like doctor/patient relationships, such relationships may (or may not) feel relatively comfortable and friendly, but they are limited by their asymmetry. More useful frameworks, such as "partnership," or "co-analyst" are available. Such frameworks encourage the active participation of the client.

In my experience, the most effective therapeutic relationships are those which feel "natural" and generally "equal." Experiencing a relationship which feels natural, healthy,

accepting, and nurturing can be therapeutic, in and of itself. Many, if not most, clients have a paucity of healthy relationships in their lives. Like many other therapists, I have had numerous clients mention to me that their relationship with me was the first comfortable, healthy relationship they had experienced, wherein they felt understood, accepted, listened to, respected, and such, and that it was very healing. I believe this is largely what is being referred to with the notion that "therapy *is* the relationship."

What then comprises a natural, healthy relationship? Certainly, it consists of the counterpoints to the previously enumerated list of dissatisfactions. The respondents who expressed satisfaction with their therapeutic relationships, identified essentially the same factors as those who expressed dissatisfaction, but inversely. That is, participants prefer being respected over being disrespected, being trusted over being mistrusted, being listened to over not being listened to, being understood over being misunderstood, ad infinitum. In short, they prefer pretty much the same thing in therapeutic relationships as they do m natural relationships.

It makes sense, then, to nurture and encourage the positive versions of these factors when developing a therapeutic relationship. This is best achieved by grounding the relationship in the client's interpretations and meaning system, rather than the therapeutic culture. In other words, to the extent possible, it is achieved by making the relationship feel natural. This is of course done in pretty much the same manner that one achieves it in healthy native relationships, by attending to the other persons needs, feelings, interpretations,. rights, comfort and discomfort, by being respectful, by listening, ad infinitum. It is certainly not achieved by acting in ways which feel to the client as if they are being objectified, patronized, viewed with suspicion, disrespected, and so on. If the therapist grounds the relationship, as suggested, these feelings will likely be avoided.

4) *Attend carefully to the client's ongoing experience of the therapeutic relationship and process.*

It is generally regarded as a given in therapy that the relationship extremely important. As mentioned previously, many therapists mantain that therapy is the relationship. This is a sentiment with which I largely agree. If this is the case, creating a sound therapeutic relationship should take initial priority, as it will serve as a foundation for everything which follows. It is important for the therapist to pace the process on the client's terms. If, as discussed above, the therapist begins by thwarting the client's needs as they perceive them, the therapeutic relationship and process may itself be thwarted. If the therapist proceeds too quickly, the client may be "scared off." If the therapist proceeds too slowly, the client may begin to believe that "therapy doesn't work," and come to view it as "a waste of time and money."

This does not mean, however, that the therapist should always let the client assert complete control over the process and content of therapy. If it becomes evident that a client is trying to control the process for "illegitimate" reasons, the therapist should introduce this as a "therapeutic issue." For example, it is not uncommon in relationship therapy for one person to attempt to control the process and content of therapy, so as to keep or increase power in the relationship. However, if there are not apparent reasons to the contrary, and if such control and power issues are not present, I believe it is best for the therapist to give deference to the client's needs and preferences in this regard.

l have heard many therapists assert that the client should never be allowed to "take charge" of the process. In my experience, if the relationship is on solid ground, very few clients attempt to do this. Most are quite satisfied to be involved in a relationship in which power is

shared. It is probably more common for clients to voluntarily lend too much of their power and autonomy over to the therapist, than the reverse.

In using a grounded therapy approach it is important to be constantly aware of the client's phenomenological experience of the therapeutic process, not just to ensure that it "feels good," but because to do otherwise is hazardous. Given that grounded therapy can only be achieved through a generally equal partnership between client and therapist, it is critical that the therapist stay in harmony with the client. Furthermore, if the therapist neglects to attend to the client's ongoing experience of therapy, the therapeutic relationship may be irreparably damaged.[16]

5) Although to some extent therapeutic relationships possess inherent satus differential, *develop the relationship mutually so that it feels generally "equal,"* keeping in mind that "equal" does not mean "identical."

It is important for therapists to remember they are being enlisted primarily for their skills, not their knowledge. The client's knowledge and the therapist's skills are equally important to the process. Therefore, therapy must be a *mutual* process, which requires a general *equality* in the relationship. Each party must feel equally invited to contribute to the process, and each party must feel equally entitled to rights of grievance.

An effective therapeutic relationship must be an intimate one. Clients must feel free to discuss subjects, experiences, thoughts, emotions, and so forth with their therapist which they may never before have discussed with anyone.

Relationships are more apt to achieve intimacy within a framework of general equality. This includes therapists sharing something of themselves, rather than remaining aloof. One way for therapist to achieve this, is to use anecdotes from their personal lives, as one would use comparative data in generating a grounded theory, for the purposes of constant comparative

analysis, and theoretical sampling. This approach gives analytical value to personal disclosure, as well as enhancing intimacy in the relationship. It also minimizes the likelihood that, although they are incorporating material from their personal life into the process, they will begin to work on their own personal issues, rather than the client's issues.

One of the keys to establishing an effective therapeutic relationship is to achieve intimacy, and all of the positive things that go with it, while minimizing the negative and capitalizing on the positive aspects of status differential. It is important that clients feel as if they are full, equal participants in the process. Yet, it is also important that the client attribute a certain amount of "charisma" to the therapist's role, such that they believe in the process. This is a balancing act which can be mor. thoughtfully and thoroughly managed with a grounded therapy approach, because such an approach keeps the therapist constantly "in tune" with the client.

6) To the extent possible, *ground the operative side of therapy in the client's everyday life, values, interpretations, understandings a meaning systems.*

Many therapeutic solutions are grounded primarily in the theories/ concepts, understandings, meanings, and so forth of the therapeutic culture. For example, if a client's problem is judged to be a function of some pathology of the unconscious, stemming from childhood trauma the attempted solution(s} will be designed to penetrate the client's defenses, so as to access and affect the unconscious. It is often assumed that, because of defenses, it is difficult to directly access the unconscious. Thus, "indirect" techniques are used, to supposedly circumvent these defenses. For example, some techniques involve the use of symbols, or metaphors, which are presumed to bypass the conscious and work directly on the unconscious. Such approaches are rather mystical. For the uninitiated (usually the layman or client), it appears that some sort of unseen, "magical" variable is at work. Somewhat over-simplistically, the client

comes in, the therapist performs "magical incantations," so to speak, and the client leaves "cured," not knowing quite what did the trick – sort of a "hocus pocus therapy." Only the therapist presumably knows what is occurring. The client is left in the dark, so as to prevent their defenses from coming into play. The client's understandings and interpretations are relegated to a secondary status.

A critical assumption being made here appears to be that not only are the resources of the conscious, interpretive mind essentially irrelevant, they are impotent, and even a potential obstruction to therapy. This appears to be much a universal assumption of theories and approaches which are noted in the notion of the unconscious.

With a grounded therapy approach, as with cognitive and insight therapies in general, the conscious, interpretive mind is given primacy. The conscious mind is directly accessible. The client and therapist can discover, analyze, discuss, interpret, reinterpret, and so forth, directly and dynamically. Through analyzing patterns of emotion, thought, and behavior, factors which have existed "below the level of awareness" (the unconscious" as an adjective, rather than a noun) may be brought into the realm of awareness, where change can be consciously and willfully attempted. The client assumes a position of power, as the active author of their own life, rather than a victim of mystical, unconscious forces. The client´s interpretations, understandings, beliefs, values, lifestyle, everyday life, and so forth become the context within which solutions are processed. The conscious, interpretive mind is open to new ways of viewing things, through the discovery or introduction of new knowledge and concepts, through appeals to rationality, through "reframing," and so forth. In partnership with the therapist, the client can discover, strengthen, and build on the innate resources of their conscious mind.

The conscious mind is capable of *will.* New awareness combined with will can serve as a catalyst for change. And, such change will be "owned" by the client, as they will have played a primary role in producing it. This is not to say that solutions, healing and change always come easily, or that this approach or any other cognitive or insight approach can solve all problems. But, solutions and change are certainly more likely to occur if the client is an active player, rather than a passive recipient. Whenever it is possible and appropriate, it is useful to incorporate the client's values, beliefs, and meaning systems into the operative side of therapy. Sometimes, through the therapeutic process, it becomes evident that a client's beliefs, etc., might be problematic. For ethical as well as procedural reasons, in such instances, it is best for the therapist to provide opportunities for the client to discover this (presumably) on their own, whereupon it can then be discussed. From what I have observed, therapists tend too often, and inappropriately, to view client's beliefs, meaning systems, and values as themselves part of the problem, as "defense mechanisms," for example. This is particularly the case if they are seen as being substantially out of the ordinary. This eliminates their potential as resources for therapy.

However, in my experience, if a client has a strong, clear set of beliefs they may be useful as a resource, to formulate a "reframe," for instance. It is not necessary or important that the therapist agree with these beliefs only that they respect and understand them well enough to incorporate them into the therapeutic process. In general, if solutions are frame within a meaning system which the client already understands and values they are more likely to be useful, durable, relevant, and to work.

A client's association with the therapeutic milieu is temporary. And, the therapeutic milieu is artificial. As I mentioned previously, what makes sense to the client during their time in the therapeutic milieu may make less sense when they 'leave its influence. For this reason, it is

important for the client's 'new skills and knowledge to be grounded in the real world, not the therapeutic world.

Therapeutic solutions must also realistically fit the limitations and resources of the client's everyday life. If they don't, they will likely drift into disuse. What may be appropriate or possible for one client maybe impossible for another. For example, a therapist's suggestion that a client do mid-day relaxation exercises to relieve stress may be unrealistic because of workplace conditions. The client's workplace may have no private, quiet location in which to do them. Or, a male client's co-workers may tease and laugh at him when he “attempts” to do them.
The danger in not fitting solutions to the client's everyday life is not only that the value of therapy will be diminished or lost, but that the client may view themselves as being responsible. They may interpret the outcome as merely one more instance of personal failure.

7) To the extent possible, *model therapeutic solutions after natural, indigenous ones.*

Although their personal experience of it may be unique, most problems for which clients seek therapy are common in society. And, they are commonly solved, indigenously, without enlisting the services of a therapist. It is useful to know something about natural healing and problem solving processes, as they occur in the real world, rather than the artificial milieu of therapy. Whenever possible, I believe it is important to model therapeutic problem solving and healing process after natural, indigenous ones. The closer a therapeutic course of action approximates a natural process, the more relevant, effective and enduring it will be. After all natural, indigenous solutions have already been shown to *work.*

However, our knowledge of natural, indigenous healing and problem solving processes is inadequate. It would be ideal for practicing therapists if large numbers of well-grounded studies of the kinds of problems which they address were available: Although a fair number of

reasonably well-grounded studies are available, they tend to focus on the substantive rather than the generic, and they tend to be somewhat limited in scope, density, and integration. Through no fault of the researchers, they also tend to be read and used by therapists as formulas to be applied, rather than as abstractions to enhance theoretical sensitivity.

## Procedures

As I maintained above, in using a grounded therapy approach, one should begin with as few preconceptions as possible. The reigning guideline in gathering information is to proceed from the general to the specific. One should always ask questions in the least leading manner possible. Each new subject area should be introduced with a "grand tour" type of question, which does not guide the client's response. For example, my favorite opening question with a new client is, "to what do I owe the honor of this visit?"[17]. My next question is always informed by the client's response to this initial question. And, the following question is then informed by the response to this question, and so forth, with questions always being posed in the least leading way, until the topic feels momentarily saturated. A topic which has already been covered can of course be brought up again, if the ongoing analysis suggests it (for the purposes of constant comparative analysis, theoretical sampling, elaboration, exploring new dimensions, etc.). What is important here is that at this point the process be guided, not by preconceptions or capricious, unguided probing, but the *evolving analysis.*

As with grounded theory, analysis begins immediately, and always guides how and where you do next. As I mentioned at the outset, I am assuming the reader has a general familiarity with grounded theory procedures, so I shall not review them in detail.[18]

The coding process itself is conducted in pretty much the same manner as it is in generating a grounded theory, albeit in truncated form:

1) Start with *open coding,* by coding for anything and everything that seems potentially relevant, without preconceiving problems, solutions, etc.

2) Begin *constant comparative analysis:* (a) Compare each coded incident to similar coded incidents. For example, if you are working with a couple experiencing frequent conflict, you would want to compare each episode of conflict with each other episode. From this you may discover particular properties of the conflict, such as relative power, resentment, fear, anger, or particular substantive issues, such as money, sex, parenting, and so forth. (b) Compare new concepts with new incidents. To continue the above example, upon comparing episodes of conflict, you may discover an underlying common theme, such as misunderstanding. (c) Compare concept to concept. In your coding you may have developed the concept of gender misunderstanding. In comparing the two codes, misunderstanding and gender misunderstanding, it will be apparent that gender misunderstanding is merely one type of misunderstanding. This will cue you to look for other specific types of misunderstanding. In doing this, you may discover patterns of interpretation from previous relationships (often referred to as "old baggage") to be another source of misunderstanding. In any event, constant comparative analysis will increase the breadth of your understanding, while simultaneously allowing you to narrow your focus down to core issues and problems.

At first compare incidents from within the particular case with which you are working, then, if useful, incorporate incidents from other similar cases. An additional technique which I have found particularly useful in therapy is to search your own experience for incidents which are as similar as possible to the client's, for purposes of comparison. This is particularly useful in a therapeutic context because the client's experience of their issues and/or problems is often very deep and intense. Because of the more personal nature of therapy, it is important for the therapist

to achieve close "verstehen," or empathetic understanding with each client, at a deeper level than is normally required by research.

3) Once a reasonably clear picture of the relevant issues or problems emerges, then begin *selective coding,* around these matters. If your open coding points to misunderstanding as a consistent theme, as illustrated above, begin coding for different properties and types of misunderstanding.

4) When it feels appropriate, begin exploring how the in vivo and substantive codes relate to each other, through the use of *theoretical codes.* [19]

5) Look for the emergence of a *core variable* or variables.[20] In the above example, through selective coding and constant comparison, you may arrive at "misunderstanding" as a core variable. Although in many instances one core variable will cover matters sufficiently, you must remain open to multiple core variables. The number of relevant core variables will he determined by the particular issues in each particular case. Unlike the theorist, the therapist cannot arbitrarily decide to eliminate a particular core variable and focus exclusively on another. This decision must be made according to the therapeutic needs of the particular client. In some instances this may produce a need to focus on multiple core variables. However, with further analysis, one often finds a relationship between these various core variables, which produces a transcending core variable, which can then become the focus of therapy. This is not a particularly unusual occurrence in therapy. Once clients' immediate issues or problems begin to subside, they often choose to tackle "deeper" personal issues. For example, a client who originally seeks help in processing a divorce may begin to perceive patterns in how they conduct relationships in general, whereupon they will want to shift from the more pragmatic concerns of the divorce to

deeper issues of self, relationships, and so forth. Upon delving into these issues, the client may then go full circle, seeing how they contributed to the divorce.

Like the theorist, the therapist must remain open to discovery, throughout the process. Because the aim is different than in generating a theory for publication, and the conditions under which the therapist works are different than those under which the researcher works, modifications to the process must be made, as each situation dictates. As a rule, whenever and to the extent possible, it is best to follow the procedures of grounded theory as closely as one can. This will maximize grounding. However, the extent to which this is possible will vary from one therapeutic situation to another. For example, opportunities for constant comparison and theoretical sampling would vary from individual, to couple, to family or group therapy. The more individuals involved in a particular case, the more one can find such opportunities with that particular case. When conducting individual therapy, such opportunities within the case are limited, as you have only one "respondent." In this instance, one must use other sources, such as the situations of other clients, including the clients of other therapists, through consultation, conversation and routine "case staffings," or as I discussed previously, even one's own personal life. In any event, the therapist must remain creative and flexible.

One clear difference between generating a theory and conducting therapy is that, because of the practicalities of doing therapy, most coding will have to be conducted *in process,* often openly, with the participation of the client.[21] Furthermore, much of the coding must occur solely in the therapist's mind. It is possible to jot down codes in the case notes, or on a separate piece of paper, as they occur in one's mind. But, because of the fluid immediacy of the therapeutic process and the number of matters which the therapist must juggle simultaneously, coding simply cannot be achieved in as thorough ·a manner as with research, nor for that matter can case notes

be as thorough as field notes. Furthermore, given typical client loads, it is simply not practical to spend separate time at the end of each 'day conducting lengthy analyses.

This mode of "coding from the hip," so to speak, requires a dexterity which can only be achieved through experience. Although in doing ordinary grounded theory research, data collection and analysis are said to occur simultaneously, they do not ordinarily occur *at the same exact time,* as most coding for therapy does.

Furthermore, although it is important to attend to the respondent's ongoing phenomenological experience of an interview, it is no: critical, because one is merely gathering information, not intervening in a person's life. In addition, the therapeutic relationship is an ongoing one, whereas the interviewer/respondent relationship seldom is (except in the case of long-term participant observation research). Plus, it is not particularly common for researchers to do group interviews, as therapists commonly do. To complicate matters even further, the therapist also has the ongoing responsibility of arriving at remedies for the client's problem(s) and finding ways in which to introduce them, either covertly or overtly into the process. And, for reasons discussed above, all of this must he accomplished with the active participation of the client, and it must be accomplished with subtlety so as to feel natural. In fact, much of what the therapist does is not visible to the client. The more the client feels the insights, knowledge, ideas for solutions, and so forth are "owned" by them, the more apt they are to be relevant, to fit, and to work. With so many matters to attend to, the grounded therapist must be ever vigilant, balancing numerous levels of thought and action, simultaneously.

Although in some ways the therapist's task is more complex than the theorist's, insofar as elaboration and integration of concepts are concerned, it is also more limited. Because it is not the task of a therapist to generate a theory for write-up and publication, the therapist need only

generate a "working theory," for a particular case. A good working understanding and explanation are all that is needed.

Another clear difference between generating a theory and conducting therapy is that therapy has an operative component. In therapy, the point of analysis is not to arrive at a generalizable theory (although with a little extra work that could be accomplished), but to arrive at solutions to the identified issues or problems, in a particular case. Although, while adding another dimension with which to be concerned, it also provides an opportunity that potential solutions can be rolled back into the process. Likely solutions can be tried, examined, refined, modified and retried, in process. Although solutions sometimes have a delayed reaction effect, their potential usually begins to evidence itself during the therapeutic process.

With any particular case, solutions can be either devised, or inherent to the process, or as is usually the case, both. Devised solutions could include anything from strategic "reframing," to "behavior modification," to teaching "communication skills," ad infinitum, depending upon what the situation suggests.

Inherent solutions are an outgrowth of simply participating in the process. For example, as I discussed previously, merely feeling listened to and understood can be very therapeutic. And, careful listening and empathetic understanding are necessary components of the grounded therapy approach. Additionally, the grounded therapy process is inherently "educational." Clients gain both conceptualized, organized knowledge and skills with which to identify and solve problems. Furthermore, whatever is achieved is "owned" by the client, as it is achieved in full partnership. All of this can be very "empowering" for the client. In fact, most often, it is best to covertly "lead" the client, such that they experience the power of ownership in the process.

## Conclusions

As I mentioned at the outset, the grounded therapy approach was devised in response to what I observed practicing therapists doing, not what is found in the literature. Therapy as it is routinely practiced is replete with a priori assumptions and preconceptions, coming from explanatory/operative constructs, the therapeutic culture and the therapeutic relationship. Less imaginative and novice therapists tend to practice what I characterize as "formula" therapy, by adhering to particular therapeutic modes in a doctrinaire fashion. Imaginative, experienced therapists tend to practice what I characterize as improvisational therapy," which may be somewhat more creative, but which may also be somewhat erratic. As I hope to have shown here, both approaches have some serious problems and limitations. Over the years, I have integrated the techniques of grounded theory with the best of what I observed other therapists doing, as well as what has worked in my own practice. The result is what I am referring to as " grounded therapy." Although grounded therapy shares a great deal with other models of therapy, in that it incorporates whatever is useful and fits, it is uniquely formulated to provide therapists with a methodology, a specific set of operational guidelines, by which to conduct both the explanatory and operative sides of therapy with creativity and without orthodoxy. And, in my experience, it is an example of the power of grounded theory.

## Endnotes

1. I wish to thank my colleagues and clients for providing the arena and experiences from which much of what is contained here was drawn. I also wish to thank my friends and colleagues Kelly Hadley and Gary Sandwick for many informative and enjoyable hours spent discussing therapy. I especially wish to thank Jo Simmons for many informative and enjoyable years spent

discussing about every imaginable facet of therapy, and for contributing to many of the ideas contained herein.

2. When I use the term "therapy," I am referring to psychiatry, clinical psychology, counseling (in its many forms), and the like. My observations, conversations, discussions and interviews have mostly been with practicing counselors, although a fair number have been with psychiatrists and clinical psychologists.

3. To avoid confusion, I might point out that since I completed my Ph.D. I have resumed the use of my birth surname, Simmons.

4. However, a book-length piece on this topic is currently in progress.

5. See Gross (1978), Masson (1988), as well as the many works of Thomas Szasz, amongst others, for discussions and reviews of the research literature concerning the failures of therapy.

6. Some critics, most notably Masson (1988) argue that therapy is useless or impossible in any form. Although I consider myself a critic of therapy as it is practiced, I believe simply eradicating therapy would be tantamount to "throwing out the baby with the bath water." As a practicing therapist, I have seen many instances in which therapy has been undeniably and profoundly helpful to clients. I am not yet ready to give up the idea that one person can help another, even if such help involves a fee.

7. Many therapists, in fact about half of psychologists who practice therapy, call themselves "eclectic" (Masson, 1988).

8. The notion of "unconscious" or "subconscious" mind, although not originated by Freud, was initially central to Freudian psychoanalysis. However, later in his career, it came to play a lesser role, much of what was attributed to it being replaced by the "id." The distinction

between the conscious and unconscious was replaced with the three part organization of the "id," "ego," and "superego." The unconscious was "demoted" to the status of merely "a quality of mental phenomena" (Hall, 1954).

9. See Thornton (1986) for a discussion of this connection.

10. The DSM-III-R is the Diagnostic and Statistical Manual of Mental Disorders, of the American Psychiatric Association (revised edition).

11. Such diagnoses are sometimes influenced by considerations other than fit, such as minimizing the potential stigma for the client.

12. Therapists would do well to follow Glaser's (1978, p.69) advice for theorists to " ... type behavior, not people ... This allows the actors in grounded theory to walk in and out of many behavior patterns without being typed as one of them. Our actors can rome unlabeled and unclassified. They can succeed here and fail there and not be failures or successes, deviate here and conform there and not be deviants or conformists, and so forth. This does not offend people, since the emphasis is on behavioral patterns, not personal patterns."

13. See Strauss (1977 and 1984) for discussions of the notion of "social worlds."

14. In my experience, this is more often the case with men than with women, because of cultural expectations regarding the male role.

15. This does not mean each case needs to be re-invented. Knowledge and concepts derived from well-grounded studies and experience at doing therapy can be used to sensitize, but not determine where a given analysis will go. The line between "preconception" and "sensitivity" is somewhat imprecise, but becomes intuitive with experience. The idea is to remain open and flexible, to avoid "pet" and "fad" concepts and explanations, and to refrain from becoming doctrinaire in one's approach.

16. Of the many "horror stories" I have heard from persons who have been on the receiving end of nutcracker therapy, one stands out. This person (a woman in her early sixties) reported that her therapist fell asleep during a session, while she was talking. When she realized he had fallen asleep, she remained in stunned silence for some time. When he finally woke up, he told· her he had fallen asleep intentionally, because she was "boring." He explained that if he merely told her she was boring, the experience. would not have sufficient impact to break through her defenses, so as to reach her unconscious. She terminated therapy. This experience was so distressing the insulting to her that she didn't seek another therapist, assuming incorrectly, that this approach was universal.

One noteworthy thing about this and many other therapeutic "horror stories" which have been related to me is that in each instance the therapist denied the insult, frequently offering a "therapeutic" justification for thoughtless, disrespectful behavior. To be sure, this problem is not confined to nutcracker therapy. The practitioners of more "humanistic," "client centered" therapies exercise their own forms of insulting insensitivity, usually by mistaking a patronizing, gratuitously sincere attitude and demeanor and a "sing songy" tone of voice for "concern," "caring," "sincerity," and the like.

17. To give a clearer idea of what I mean by "grand tour questions" consider the following (note that each of these examples is more specific, a topical than the one I posed in the text):

A. "Please tell me about a typical day in your life."

B. "Tell me about your family, growing up."

C. "What was life like when you were a child?"

D. "What do you think the future holds for you?"

E. "Tell me about your relationship."

F. Etc.

18. Therapists who want to learn and use a grounded therapy approach would do well to learn how to do "pure" grounded theory first. This will allow them to approximate grounded theory procedures to the extent that their particular therapeutic situation allows. For a detailed illumination of the techniques of doing grounded theory research upon which the procedures of grounded therapy are based, see Glaser (1978).

19. For a discussion of theoretical coding "families," see Glaser (1978 pp. 72-82).

20. In therapy, the core variable can be a core problem or issue, or it can be the central variable which "drives" a problem or issue . In either instance it is the (or one of the) variable(s) which is central to the individual´s life. Some core variables will be exhibited as strong patterns, which are not necessarily conscious to the client(s). Chronic misunderstanding between parties to a relationship is an example of such a core variable. Other core variables, such as chronic resentment, chronic anger, or chronic feelings of worthlessness, may be closer to a client's consciousness. To discover this second type of variable, while coding, it is useful to address the question "what is the client working on?)' (such that they are engaging in a particular pattern of emotion, thought and/or action).

21. For this reason, it is particularly important that concepts have imagery, as well as analytical ability, so they will be understandable appealing and memorable to clients. As Glaser (1978, p.70) points out, in vivo codes usually have vivid imagery. Concepts with vivid imagery will have more power in the therapeutic process.

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