Clients' Deference in Psychotherapy

David L. Rennie

In the present study, 14 psychotherapy clients were interviewed about their recollections, assisted by tape replay, of an immediately preceding therapy session. A major category derived from a grounded theory analysis of the interview protocols was client's deference to the therapist, constituted of 8 lower level categories: concern about the therapist's approach, fear of criticizing the therapist, understanding the therapist's frame of reference, meeting the perceived expectations of the therapist, accepting the therapist's limitations, client's metacommunication, threatening the therapist's self-esteem, and indebtedness to the therapist. The P. Brown and S. Levinson (1987) model of politeness in discourse both informs and is informed by the results of this study, which are also discussed in terms of recent literature on the client's covert experience and in terms of their implications for the practice of therapy.

Apart from some notable exceptions (e.g., Orlinsky & Howard, 1975; Strupp, Wallach, & Wogan, 1964), until recently psychotherapy researchers generally have shown little interest in seeking clients' reports on their experience of therapy as a way of extending the understanding of the process of therapy. Historically, this lack of interest can be traced to the influence of behaviorism, positivism, and psychoanalysis, all of which, for different reasons, have contributed to the field's misguided thinking about the value of verbal reports of conscious experience (cf. Ericsson & Simon, 1980; Nisbett & Wilson, 1977). Lately, however, in the wake of the cognitive revolution and, in some instances, of the social constructionist movement (see Gergen, 1982, 1985), psychotherapy researchers have applied both the natural science approach and the human science approach (see Hoshmand, 1989; Polkinghorne, 1988; Rennie & Toukmanian, 1992) to gaining and analyzing clients' accounts of their experience of therapy (for reviews see Elliott & James, 1989; McLeod, 1990; Sexton & Whiston, 1994).

In expression of the human science approach, for example, I conducted a study of clients' moment-to-moment experience of an hour of therapy. Over the last decade, a discovery-oriented approach to inquiry was carried out through an application of Kagan's (1975) technique of Interpersonal Process Recall (IPR), which was originally developed as a way of facilitating counselor training, to this investigation of therapeutic process (cf. Elliott, 1979, 1983, 1986). The grounded theory (Glaser, 1978; Glaser & Strauss, 1967) form of qualitative analysis was applied to the transcripts of these inquiry interviews. In this analysis, it was evident that much of the clients' recalled experience was of moments in which they had been self-aware and deliberative both in thought and in dialogue with the therapist. The recollection of this type of experience prevailed over the recall of nonreflexive experience—that is, moments in which the clients had been immersed in intentionality in the absence of self-awareness (see Searle, 1983, regarding an intention-in-action). Supported by the particular results of the grounded analysis, I accordingly have conceptualized client's reflexivity, which I have defined as the client's self-awareness and agency within the self-awareness (cf. Harré, 1984; Husserl, 1913/1976; Lawson, 1985; Slife, 1987), as the core (i.e., the most central or unifying) category colligating all other categories derived in the analysis. The categories it subsumes are organized in a hierarchical structure consisting of three levels. The first of these levels consists of 4 main categories entitled client's relationship with personal meaning, client's perception of the relationship with the therapist, client's experience of the therapist's operations, and client's experience of outcomes. Beneath each of these main categories are 2 to 3 categories serving as their properties. Finally, the categories in this last level have as their properties 51 categories, constituting the lowest level of the hierarchy (Rennie, 1992). Thus far, I have given an overview of the results of the study bearing on the first 2 main categories (Rennie, 1990), outlined the taxonomy and addressed the core category (Rennie, 1992), and represented the client's experience of resistance (Rennie, 1994a) and of storytelling (Rennie, 1994b) in therapy. This article extends the presentation of the returns from this research program by focusing on client's deference to the therapist, a major property of client's perception of the relationship with the therapist.
Deference

Deference is commonly defined as the submission to the acknowledged superior claims, skill, judgment, and so forth of another person. In the therapy dyad, the therapist is generally considered to be more expert than the client—a situation that could be expected to potentiate the client’s deference to the therapist. This phenomenon has received little attention in the literature on the client’s relationship with the therapist, however. Instead, attention has been directed to concepts presumed to relate to the process of improvement in therapy, particularly transference (Freud, 1913/1963), resistance (see Strean, 1985), empowerment (Beck, 1976; Ellis, 1962; Perls, Hefferline, & Goodman, 1951; Rogers, 1951), and the working alliance (Bordin, 1979; Greenenson, 1967; Horvath & Greenberg, 1986). Furthermore, although some recognition has been given to the client’s “real” relationship with the practitioner (Ellis, 1983; Greenenson, 1967; Lazarus & Faye, 1982), this aspect has been examined in the context of clients’ nontransferral resistance (Rennie, 1994a) rather than in the context of deference.

While doing the grounded theory analysis, my familiarity with deference was limited to the knowledge of the common meaning of the term; nevertheless, the concept seemed pertinent to aspects of the clients’ reports. A subsequent search revealed that there is relevant literature derived from symbolic interactionism (Mead, 1934). Important in this respect is the work of Goffman (1967), who views deference as a type of facework, in which the speaker maintains and enhances both his or her and the hearer’s self-esteem. Goffman’s formulation in turn stimulated Brown and Levinson (1987) to construct a model of politeness that includes deference. In this model, politeness is expressed in the form of five basic strategies available to the speaker as he or she decides how to deal with a desire to conduct a face-threatening act (such as wanting to ask a favor or to criticize the hearer). These five strategies are ranked according to the threat posed by the act, with the threat being the summation of the distance between the speaker and the hearer, the relative power held by each, and the magnitude of the imposition contemplated by the speaker. The strategies range from being baldly direct when under low threat to keeping silent when under high threat. Midway is the strategy of negative politeness, defined as the decision not to invade the hearer’s claims of territory and self-determination. Thus, in being negatively polite, the speaker engages in discourse that gives way to the hearer’s self-determination at the expense of the speaker’s own. Within this framework, deference is characterized as a form of negative politeness.

Brown and Levinson’s (1987) characterization of deference pertains to discourse, and the same is true of other work on politeness (e.g., Wood & Kroger, 1989). Although the model is based on the notion that intentions underlie speech acts (see Searle, 1983), the focus on discourse leaves much of the intentionality hidden. Accordingly, Brown and Levinson suggested that silence may be ignored because “there are naturally no interesting linguistic reflexes of this last-ditch strategy” (Brown & Levinson, 1987, p. 72). The results of the present study revealed, however, that its participants primarily were silently deferential. Hence, the results open a door to understanding unexpressed deference and fill in the part of the Brown and Levinson model left vacant by the limitations imposed by its focus on discourse. In turn, the results raise implications for the practitioner’s conduct of psychotherapy as one of the many fiducial relationships constituting professional practice.

Method

Clients

Fourteen clients who were actively in therapy were recruited through the cooperation of their therapists. The clients ranged in age from the mid-20s to the mid-40s. There were 6 men and 8 women. None was of a cultural minority. They had been in therapy for a period ranging from 6 weeks to over 2 years. Twelve were being counseled by therapists working in the counseling center of each of two large Canadian universities; 2 were receiving therapy from a private practitioner. With the exception of 3 clients who were in the labor force, all were undergraduates. Two of the clients in the labor force had a postgraduate degree. Hence, almost all of the clients had an above average education. No attempt was made to obtain from their therapists psychodiagnostic information about these clients. My clinical impression was that none suffered from a psychotic disorder; a follow-up 3 years after one client was interviewed revealed that she had, in the interim, periodically been an inpatient for the treatment of a manic–depressive disorder, according to her account.

Therapists

The therapists in the study consisted of five women and six men (two of the therapists saw two clients each). Seven were psychologists with a doctorate, two were graduate students in clinical psychology, and two were social workers with a master’s degree. All of the therapists had at least 5 years of experience. They collectively adhered to person-centered, gestalt, transactional analytic, radical–behavioristic, rational–emotive, and eclectic orientations. I was one of the therapists, and two of my clients agreed to participate. One of these clients was interviewed (by a colleague of mine) about one session. The second client was interviewed by another colleague about two sessions.

Inquiry Procedure

All of the clients were actively in therapy at the time of the study. In the case of 12 participants, the inquiry was into the experience of a single session of therapy. In the case of the remaining 2 clients, the inquiry was into the experience of two sessions, separated by 3 weeks in one case and by 4 months in the other. In all, an inquiry was made into 14 clients’ experience of a total of 16 therapy sessions.

Each client brought to the recall consultant (after Elliott, 1979) either a videotape (in 5 instances) or an audiotape (in the remaining 11 instances) of the therapy session under study. I was the recall consultant for all participants except for my own clients. In all but one case, the inquiry was conducted immediately after the session; the exception was a delay of a week for the first research interview. In our application of the technique of IPR (Kagan, 1975), the tape was replayed and the clients were invited to stop it
Overview of the Grounded Theory Method

The development of the grounded theory approach to human science has been described in a series of monographs by its originators (Glaser, 1978; Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1990). The task set by grounded theorists is to understand and represent the meaning of information about human experience and behavior. An effort is made to make the formulation within a naïve attitude in which biases, expectations, and hypotheses are put aside, or bracketed (see Giorgi, 1970). The object of the investigation may be any human experience about which information is available. The information is usually textual—either extant as literature, produced by the participants in the study, or produced by the researcher in the role of a participant observer of the phenomenon under study. Data gathering and analysis proceed concurrently. At the outset, a few sources of information (such as two or three people who are familiar with the phenomenon) are selected, and the information provided by them is systematically studied. On the basis of the understanding arrived at during this analysis, new data sources are selected, and the information derived from them is entered into the analysis. The data selection and analysis proceed cyclically until it is found that the information from new data sources adds little to the understanding of the phenomenon, at which point the categories (see below) resulting from the analysis are judged to be saturated.

The development of grounded theory is based on the method of constant comparison. The text of a given protocol is broken into units of analysis (often termed meaning units; MUs) and summarized. The MU summaries (often referred to as codes) are compared within and between protocols in the search for commonalities of meaning, as understood. The commonalities are given labels, referred to as categories. The categories are compared within and between protocols in further searches for commonalities. Commonalities among categories are conceptualized as higher order categories. This conceptualization thus gives rise to a hierarchical structure, with the categories in each level serving as the properties of the category subsuming them. Eventually, a supreme higher order category, termed the core category, is conceptualized. The core category is thus grounded in the categories it subsumes, just as the categories beneath it are grounded in the categories beneath them, as the lowest level categories are grounded in the codes, and as the codes are grounded in the data. In addition, depending on the phenomenon, the hierarchical structure may be cast within a process model that takes into account developmental changes over time. Overall, grounded theory is both descriptive and interpretive and as such falls between the empirical phenomenological (see Polkinghorne, 1989) and hermeneutical (e.g., Gadamer, 1960/1989) genres of human science.

The grounded theorist records his or her reflections on the study as a whole and on the analysis in particular. These theoretical memos are written to help the researcher to bracket his or her implicit assumptions and hunches during the course of the analysis. As the analysis reaches its final stage, these theoretical memos contribute to the formulation of the theory that is grounded in the categorical structure.

In their earlier works on this method, Glaser and Strauss (1967) and Glaser (1978) have stressed the importance of theory generation more than theory verification, indicating that, while the grounded theorist may wish to put his or her theory to the test, this was not necessary and that the testing could be done by other investigators. More recently, Strauss (1987; Strauss & Corbin, 1990) has shifted toward advocating a method of internal verification of categorization, wherein rational speculation about the possible sources of the information in a given unit of analysis gives rise to hypotheses that are then tested by the new data as the analysis proceeds. This development in Strauss's thinking raises issues that go beyond the scope of this article. In any event, the use of the grounded theory method in the present study was in keeping with Glaser and Strauss's earlier approach, as have been the majority of investigations involving the method (Quartaro, 1993).

Horizons of Understanding

I was trained as a clinical psychologist and for the past 20 years have specialized in psychotherapy, both as a practitioner and as a trainer. Although I sometimes draw upon the principles of behavioral therapy and of psychoanalytically oriented therapy, my preferred orientation is person-centered—experiential, and my interest is primarily in the role of clients' consciousness in personal empowerment. During the early stage of the grounded analysis (i.e., before the first papers and articles derived from it were written), I followed Glaser and Strauss's suggestion to refrain from reading relevant literature as a way of facilitating the adoption of a naïve attitude toward the data of the study. Nevertheless, I was involved in Phillips's (1984) dissertation (as his supervisor), which was a grounded theory analysis of clients' accounts of the major influences on their lives during the time when they were in psychotherapy. Phillips's study alerted me to the importance of self-focus in the client's experience of therapy.

In terms of method, I am now a committed human scientist, after having practiced the natural science approach for the first half of my academic career, and have increasingly come to believe that human science is most appropriately seen as a constructionist enterprise.

Credibility of the Present Analysis

It is acknowledged that, in the grounded theory method, different analysts may develop somewhat different categories and, correspondingly, a somewhat different theory from the same set of data; this scenario is acceptable provided that each analysis is grounded in the data (see Glaser 1978; Glaser & Strauss, 1967; Maxwell, 1992). Although the disparities will not be extreme in this circumstance, the relativism involved in grounded theory analysis challenges the analyst to convince his or her audience that the returns from the analysis are grounded and not solipsistic (Rennie, 1993). In this section, the efforts made to ensure that this representation of the client's experience was grounded and coherent are described.

In this study, I developed the tactic of immediately conceptualizing categories while attending to the meaning apparent in each individual MU (see Rennie, in press; Rennie, Phillips, & Quartaro,
1988). Thus, when dealing with a given MU, which typically ranged from a few lines to over a page of text, I pondered the unit, wondering “What meaning is contained here?” The result could be a single answer or several. Each answer was represented by a word or phrase tied to the meaning of the text of the MU, and called a category. In some instances, the language of the category was closely tied to the language of the MU, such as conceptualizing the category client’s track when interviewees used the terms on track and off track when commenting on thinking during a given moment in therapy or on the aptness of their therapist’s response. In other cases, the language of the category was not actually contained in the language of the MU, as when the category concern about the therapist’s approach was derived from a MU in which an interviewee reported having difficulty with what the therapist was doing, but did not express the difficulty in terms of concern or approach.

The analysis was organized through the use of two sets of (index) cards. On the cards of one set was entered the text of each MU together with its identifier and a list of the categories to which it was assigned. The second type of card was termed the category card. A different card (or set of cards) was created for each category. When a given MU was judged pertinent to a given category, then a compact gist of the text of the MU was written on a single line of the category card and identified. The category card(s) thus accumulated one-liners from both the given client whose protocol was currently being analyzed and from all other protocols for which the category was pertinent.

The one-liners of the category card(s) provided a compact representation of the meaning in the MUs assigned to the given category. Correspondingly, scanning the array provided an overview of the shades of meaning across the MUs derived within and among the participants, which sometimes led to a renaming of the category. This technique also enabled a convenient means to compare the relationships among categories, which facilitated the development of the hierarchical structure of categories and which made it apparent that some categories were redundant and could be pooled.

This tactic thus differed from Glaser and Strauss’s tactic of categorizing consequent to the sorting and resorting of codes into clusters. In their procedure, the returns from the activity of clustering provide a basis for judgment about saturation. In the tactic used in this study, each category at the point of its conceptualization was an ideal type. As such, the category was, of course, pertinent to the MU giving rise to it, but it remained to be seen whether or not it would be applicable again. Because its subsequent applicability was represented on the card(s) pertaining to a given category, the number and sources of the entries on the card(s) constituted my index of saturation of the category, while the extent to which no new categories seemed necessary was an indicator of the saturation of the taxonomy. Although I was not aware of it at the time, Turner (1981) had published a similar procedure.

During the analysis, some categories were renamed, others were pooled, while still others were discarded. Toward the end of the analysis, two undergraduates conducted projects (Kovac, 1990; Solish, 1989) to facilitate the development and refinement of a manual of the taxonomy (Rennie, 1989). In the manual, each category was defined and illustrated within the framework of a template. The research assistants found that, in the main, they could relate the categories to the data. However, they found that, in a few instances, there was too much overlap among categories. These observations led to further refinement of the taxonomy.

Results

In the overall study, the analysis was performed on 1,118 MUs and, as indicated, resulted in the conceptualization of a hierarchical taxonomy. There were 3,051 assignments of the MUs to the 51 categories constituting the lowest level of the hierarchy; 8 of these categories were properties of client’s deference to the therapist.

The clients’ experience of the properties of client’s deference was variable. The clients experienced some of them more than others. Some clients experienced more of the properties than did other clients. In a given moment in therapy (represented by a MU), only one property may have been pertinent to the client’s experience, while in another moment several properties may have been involved. It was never the case, however, that all eight properties were experienced during the same moment.

The representation of client’s deference is given in three sections. In the first, each of the eight properties is described. The first four properties were highly saturated, in the sense that they applied to most of the participants and often occurred several times over the course of the therapy session. The next four properties were less saturated, applying to as few as 4 of the 14 participants. Nevertheless, in the grounded analysis, these four properties were judged to be sufficiently distinctive and saturated to warrant keeping them (as opposed to pooling or discarding them). In the second section, particular moments in which clients felt deferential to their therapist are given in detail to illustrate the lived experience of deference; in this section, how the properties of clients’ deference are grounded in the data is also illustrated. In the last section, the experience of deference is represented theoretically and thematically.

Properties of Client’s Deference

Concern about the therapist’s approach. This property represents the client’s concern about the therapist’s plan for or strategies used in the therapy. The term plan is defined as the overall objective for treatment. Strategy refers to a given technique used in the enactment of a plan. The clients revealed in the inquiry session that they actively appraised their therapist’s plan and strategies, contrasting them with their own preferences. In their experience, conflict over a plan constituted a major disjunction in the therapy. Alternatively, concern about a strategy varied in its seriousness, depending on whether clients agreed with their therapist’s plan.

Fear of criticizing the therapist. This property represents the client’s fear of criticizing or challenging the therapist. The category is broad enough to encompass the reluctance to criticize as well as the actual fear of criticizing. In a given instance, there may be any of a number of reasons for clients not wanting to criticize. Clients may feel that it is not their place to question their therapist’s approach because they view themselves as naive laypersons and the therapist as an expert who probably knows what he or she is doing, even though it is not immediately obvious. Related to this
reason is a concern about manners: They may feel that it would be impolite to criticize. They may also feel that it would be childish and petty to express any criticisms, that the adult approach is to curb their inner demand that the therapist be perfect. Similarly, they may attenuate the concern over the troubling aspect of the therapy by contextualizing it within the benefits both gained and possibly to be gained from the therapy as a whole; this reason is reinforced by the feeling that criticism would defy the gratitude felt toward the therapist. Finally, they may worry that criticism would hurt the therapist's feelings, and jeopardize their relationship with the therapist.

Understanding the therapist’s frame of reference. This property represents the client’s interest in understanding the therapist’s subjectivity. It pertains to the experience of actually understanding the therapist’s frame of reference, of being interested in or curious about it, or of being concerned about it. Interest and curiosity are typically motivated by a desire to close the distance between the client’s and the therapist’s frameworks. The concern may involve clients either being confused about what the therapist is saying or doing, or wishing to understand the reasons for the therapist’s conduct so that it can be dealt with more effectively.

Meeting the therapist’s perceived expectations. This property addresses the client’s sense of pressure from the therapist’s demands or apparent expectations and how the client responds to the pressure. The property is broad in the sense that it addresses the client both meeting and not meeting the therapist’s apparent expectations. First, at one end of this range of behavior, the client may willingly comply with the therapist’s wishes in the interests of furthering what the client experiences as a good working relationship with the therapist. Second, in the absence of concern about the therapist’s approach, the client may comply because he or she wishes to please the therapist—to be a good client. Third, the client may feel uneasy, even querulous, about the perceived expectation but remembers that compliance to the therapist proved to be useful in the past despite scepticism at the time, and thus complies. Last, the client may feel that the pressure is unacceptable and rebels against it.

Accepting the therapist’s limitations. This property represents the client’s tolerance of the therapist’s mistakes or misunderstandings. There are several reasons for this tolerance. First, the aspect(s) of the therapist’s work giving rise to negative evaluation may be associated with aspects of the work that are evaluated positively; the client may draw upon this realization and tolerate the negative aspects. Second, negative appraisals of the therapist may not be so strong as to interfere with the client’s work in the therapy, and so the client carries on with it. Third, the therapist may be recognized as being “simply human” and therefore expected to make mistakes from time to time. Fourth, the client may grant that misunderstandings sometimes arise because the client has not revealed all that he or she has been thinking, and that the therapist cannot be expected to be omniscient. Finally, the client may acknowledge that the therapist cannot be expected always to see things the way the client sees them.

Client’s metacommunication. This property has to do primarily with the client’s felt need to communicate with the therapist about their communication when such communication does not in fact occur. First, the client may send out a signal—either nonverbally, paralinguistically, or linguistically in a subtle way—that he or she is having difficulty with the therapist’s communication, with the hope that the therapist will pick up the signal and allow the client to explain the basis for it, only to find that the signal is not picked up by the therapist. Second, the client may feel that he or she should comment on how the therapist’s communication is affecting the client but finds this confrontation difficult to put into effect; this reluctance may extend to the client’s not being honest with the therapist even when the therapist has invited the client to metacommunicate in this way. Finally, the client may wish that the therapist would reveal the rationale or intentions lying behind the latter’s communication as a way of helping the client to come to terms with it.

Threatening the therapist’s self-esteem. This property represents a relatively rare occurrence in which the client verbally attacks the therapist in a moment when the client feels relentlessly pressured by the therapist. The attack is motivated by a need to reduce the therapist’s power and authority. The client feels precarious in such a moment; the attack is made indirectly and subtly, with considerable dread of retaliation, and the client quickly defers to the therapist to offset this possibility.

Indebtedness to the therapist. Represented by this final property of client’s deference is the client’s experience of feeling grateful to the therapist for being interested in the client and for the therapy received. The client may feel that, in the main, the therapist has been helpful and wants the therapist to continue helping. The client may also be aware of the one-sided nature of the relationship and may feel indebted to the therapist for allowing the client to be the focus of attention at the expense of attention to the therapist. Finally, the feeling of indebtedness may be strengthened when the therapy has been subsidized so that the client has not had to pay for it; the client may ascribe to the idiom that beggars cannot be choosers. All of these feelings may contribute to the client’s reluctance to challenge the therapist during moments of negative feeling about the therapist or the therapist’s performance.

Two Illustrations

The following section provides an excerpt from the reports of each of 2 clients to illustrate the properties of client’s deference. Both clients were in long-term therapy. The first client experienced a positive relationship with her therapist. However, there was a difficulty during therapy that was privately experienced as distressful. The second client’s experience, by comparison, was mixed. She appreciated her therapist’s strength of character and her guidance. Nevertheless, she sometimes was concerned about the degree of control that the therapist exerted; related to this concern was a worry that she was perhaps too compliant to
the therapist. The categories of each excerpt are listed at the end of each passage to illustrate the grounded theory analysis. This categorization is the actual analysis of these passages, thus the categories include but are not limited to the properties of client's deference. In these excerpts, ellipses indicate places in which a word or phrase was deleted to improve the readability of the passage.

Illustration 1. This dyad consisted of a female undergraduate in her 20s and a female therapist in her 50s. In their therapy session, an early theme had been the client's self-pity. This theme was still in the air, although at this particular point in the session the discussion had moved to the client's concern that she was not responding well to the competitiveness of university life. The client had remarked, "But I want to just tell myself, 'You're here, so just do it.'" The therapist had then replied, "Is there something stopping you?" to which the client had responded, "Me." The therapist had then said, "Or just doing that..." whereupon the client had paused for a long time.

In the inquiry session, the client stopped the tape at the pause. She revealed that, in a therapy session prior to the one under study, she had been trying to understand why she pitied herself so much. She reported that her therapist, who was generally very supportive, was unsympathetic to this question of "Why?" The therapist felt that this question was not useful and that, instead, the client should concentrate on simply accepting her self-pity and working from there. The client revealed in the inquiry that she had since heeded her therapist's wishes in terms of what she verbally focused on in her sessions with her therapist but that, inwardly, she was still preoccupied with the question of "Why." This preoccupation had privately been going on during the above exchange with the therapist. While the client was talking about her difficulties in competing at university, she was inwardly linking the difficulties to her ongoing preoccupation. Hence, when the client had heard the therapist use the phrase "Or just doing that..." the client had interpreted the phrase as another reminder that she should engage in action instead of continuing to dwell on the "Why" question. Nevertheless, she had not been able to help herself. Inwardly, she had wanted to try to get to the bottom of why she was feeling and acting the way she was and yet, because of the therapist's constraint, the client had felt that she could not once again raise the "Why" question. As she said in the inquiry session,

She's telling me that I rip myself up too much. And when she says...to try not saying, "I should do this, I shouldn't be this," and try saying, "You are upset." Or instead of saying, "I shouldn't be upset," say "I am upset." Okay? Then I'm always left with...just another question that I can't pose to her because I feel like I'm just wiping out what she's trying to do. Because my questions are always, "Why can't I do this?" or "Why can't I just stop questioning myself?" And then I have another question: "Why can't I just not 'should'?"...But she's telling me not to ask those questions so that I can't ask her, "Why should I?" [advice by therapist, root of problem, trust in therapist, concern about the therapist's approach, meeting perceived therapist expectations, fear of criticizing the therapist, resistance by client, client evaluates own processes]

Thus, in not being able to do what the therapist had suggested, the client had not known where to go in the therapy. Hence the pause.

Illustration 2. The second illustration came from a moment in the meeting between a woman in her 30s and a female therapist in her 40s. At a certain point in the session, the therapist had answered the telephone. The client had made no remarks about the interruption to her therapist during the session, but in the inquiry she revealed that she had had two main reactions. First, she had felt annoyed. Lately, the therapist had indicated that she had been especially busy, and she had asked for the client's permission to answer the phone at times, which the client had given. Having given the permission, the client had not always felt annoyed. However, today she had been, for some reason. She thought that the annoyance may have been linked to a second thing that she had inwardly been experiencing, which was a hunch that the therapist may have had an ulterior motive in answering the phone in the client's presence. Knowing that a theme of the therapy had been assertiveness, the client had had a feeling that, in answering the phone, the therapist had been modeling how the client should behave when dealing with people. She had not liked this possibility. As she said in the inquiry session,

Sometimes she'll say, "It will take a minute," and she ends up spending 4 minutes, and I don't like that. And sometimes it just gets out of hand and I sometimes wonder if she's used the conversation she has with people to show me how to deal and cope with people—how to ask for what you want; how to be clear and precise about what you do not want, and I don't think it's appropriate. I don't want to be taught by these methods...I don't ask her why she does certain things. I almost wonder if the role gets reversed, and me sitting there saying to her, "I notice this about you, and I'd like an explanation." I'm not sure how to approach that...I suppose if I spoke to her as an adult and it's just information then it would be okay to do that. Uh, no: I've, I've never risked asking her that. All I did was make a clear decision. [Interviewer: You're sensing there is a risk involved?] Well, I don't know how she would take that—my telling her or letting her know that's how I perceive her. I don't know. I don't know if it would be threatening or, I mean—I guess it's a paranoia or resentment and all I would be doing is...If I tell her that, would it—Am I off the wall? I guess I'm not willing to risk that one. [therapist's manner, therapist's care, therapist's directiveness, concern about therapist's approach, understanding the therapist's frame of reference, fear of criticizing the therapist, client evaluates own processes, therapist's evaluation of the client, acceptance by therapist]
tion with Goffman's (1967) analysis of facework, I have come to realize that many, if not all, of the properties of deference relate to facework. In addition to this dynamic, it is important to look at the relationship between the experience of deference and the overall flow of the therapy session. This final section of the presentation of the results addresses these two aspects.

**Facework.** Although it is a tautological observation in the sense that deference, by definition, has to do with human relations, it is essential to keep in full view the fact that the clients’ deference to their therapists was embedded in their relationship with the therapist. This relationship was experienced in two different but related ways. First, the clients realized that the therapist was a person and, irrespective of the therapist’s authority, they generally did not wish to hurt his or her feelings. (Occasionally they did actually threaten the therapist’s self-esteem but, as mentioned, this was rare, and was quickly followed by reparation). Thus, the clients protected the therapist’s face through the ordinary application of tact. Second, and more fundamentally, the concern about the therapist’s face derived from the asymmetry of the relationship. Although the clients did not express their concern in such terms, their reports supported the interpretation that, in entering therapy, they effected an implicit contract to assume the role of patient in the care of the therapist as agent. The role of being a patient is to acquiesce to treatment, not to question it. Thus, the clients were reluctant to challenge the therapist’s authority. Indeed, they made efforts to enhance that authority by attempting to understand the therapist’s frame of reference so that they could attune their discourse to it, and thereby make the therapist’s task easier, and by complying with the therapist’s direction out of respect for the therapist’s judgment.

This assumption of the patient’s role was not complete, in the sense that the clients completely stopped being agential. By virtue of their reflexivity, the clients usually just refrained from being openly agential in their interaction with their therapists when dealing with their concern about the therapist. Sometimes they gave a subtle indication of the concern, as when one client reported that, when she found that she had unwittingly entered the process of mentioning her boyfriend’s name despite an avowal never to do so again after her therapist had indicated that she did not like him, the client dropped her voice midway through saying the name with the hope that the therapist would not notice it. More often, however, the clients were covertly agential by saying one thing while thinking another, by paying attention selectively to the therapist’s offerings, by complying with the therapist while feeling skeptical, and so on.

Another factor that made the clients cautious when dealing with their therapists was the power vested in the therapist by virtue of his or her authority. The therapist was seen to have arcane knowledge that could help, but that could also hurt. The therapist’s opinion of the client was thus highly relevant to the clients’ sense of face. At times, they engaged in maneuvers to influence the therapist’s impression of them as persons, as a way of protecting and enhancing their face, as when the same client who dropped her voice made a point of reporting light, lively dreams to her therapist in an attempt to convince her that she, the client, was a normal, creative individual and not the stodgy neurotic she sensed her therapist thought her to be. Furthermore, despite the expert role accorded to the therapist, the clients did not necessarily trust the therapist to be objective in response to a challenge. There was a concern that the therapist might retaliate, and with the full weight of his or her special knowledge. Finally, in a related vein, it was important to the clients to have the therapist believe that they believed in the therapist, so that the therapist would feel good about them as patients. This need contributed to their inclination to tolerate the therapist’s faults, within broad limits, and to feel grateful to the therapist.

**Deference as inner theme.** It was also evident from the participants’ accounts that a negative appraisal of the therapist competed with their attention to the part of their experience being addressed in the discourse with the therapist. In this state they generally overtly attempted to maintain the integrity of the approach or direction taken by the therapist—to be “good clients”—while underneath feeling uncomfortable about the therapy. Sometimes the preoccupation was brief. For example, the client who had trouble about the telephone got over her resentment toward her therapist as the session progressed. At other times, the inner disturbance lasted throughout the session, and even beyond. Thus, the client who was concerned about her self-pity reported in the inquiry session that, although she had gotten a fair amount out of the therapy session, she was also dissatisfied because her inner preoccupation with her “Why” question had not been resolved.

As an observer, it seemed to me that, at times, the clients’ internal reactions against the therapy reflected their resistance. Some gave a grudging concession that what their therapists made them do actually worked in some instances and might work in others. In the same token, it also often appeared that they had legitimate grounds for their inner querulousness, and I inwardly sympathized with the participants as they agonized—as they often did—over the question of whose judgment was correct: their own or that of the therapist.

**Discussion**

This was an exploratory, time-consuming study into a sensitive subject. Some of the sensitivities involved necessitated certain compromises when recruiting participants for the study. In addition, the procedures used in the inquiry sessions and in the analysis raise questions about the interpretability of the results. Some of these concerns address limitations of the study, whereas others are perhaps more contentious; all need to be discussed before turning to a comparison of the results with relevant literature and to the implications of the study.

First, there is the matter of the representativeness of the participants. The search for clients who were actively in therapy created difficulties in recruiting participants. Some of the therapists who were approached did not want to involve their clients in the study. Those who were willing...
were faced with the decision of who among the members of their clientele they would approach. This decision was not made randomly; instead, the therapists used their own criteria in selecting their nominees. It may be presumed that they took into consideration factors such as the client’s interest in the project and whether he or she would find it unduly stressful. Thus, the therapists’ decisions may have resulted in the recruitment of a group of clients characterized by relatively good working alliances compared with other clients on the therapists’ caseloads (cf. Hill, Thompson, Cogar, & Denman, 1993). A related point is that none of the participants was a member of a cultural minority and all were members of the middle class. They were almost all university students or graduates and were thus, perhaps, more psychologically minded and articulate than members of the general population. This factor, combined with the mode of selection of the participants from their therapist’s caseloads, raises a caveat about the generalizability of the results of the study.

If the therapists indeed tended to nominate their best clients, this tendency did not result in a consistently positive portrayal of the clients’ experience of their therapy session. This result can be interpreted to mean that even the best working relationships entail the occasional undercurrent of negativity. On the other hand, the extent to which negativity about the therapist was part of the clients’ experience may have been distorted because of the free recall feature of the inquiry procedure. This procedure gave the clients primary control over the decision about what to address as they replayed the tape of the therapy session. Meanwhile, they had just emerged from the therapy session and were still immersed in the feelings left over from it. In turn, they were now meeting with the recall consultant, a neutral and attentive listener. It is possible that the inquiry session provided them with an opportunity to deal with some of the negative feelings about the therapy session that they did not feel free to discuss with the therapist. In this sense, then, the recall consultant may have been led by the client to attend to this residue of feeling at the expense of some of the more positive things that occurred in the session. Still, to the extent that this bias was operating, it may have compensated to a certain extent for the bias in the selection of the participants.

Another limitation of the study is that the IPR procedure may have contributed to my construction of clients’ reflexivity as the core category. The IPR task calls upon participants to be reflexive in the sense that they are asked to attend to their past experience as an object, as it were. The challenge imposed on me was to differentiate between recalled reflexivity and reflexivity that was extorted (M. Westcott, personal communication, June 1992) by the IPR procedure (see Rennie, 1992, for further discussion of this point). It is also possible that the IPR task contributed to the recall of reflexive moments at the expense of nonreflexive moments. It could be argued that nonreflexive consciousness is more easily lost in the stream of consciousness (James, 1890/1950) and hence is less memorable compared with reflexive consciousness. Both aspects—the procedural and the phenomenological—may have unduly highlighted their reflexivity in the clients’ experience of therapy.

Lastly, there is the matter of how the categories in the present study were arrived at. As seen, although I took pains to ground the categories through the development and use of a systematic approach to categorizing, and although I engaged assistants in the manualization of the taxonomy, the fact remains that the main conceptual work was carried out by a single person. Whether this approach was problematic depends on the position taken on what has been referred to as the logic of human science, but which is more appropriately referred to as its rhetoric (Gergen, 1982; Russell, 1991; Weimer, 1979). The matter of what constitutes an appropriate rhetoric has been debated at length (e.g., Giorgi, 1970, 1989; Maxwell, 1992; Miles & Huberman, 1984; Mishler, 1990; Rennie, 1993, in press; Smith & Heshusius, 1986). It can be argued that, despite my attempts to be thorough, my reliance on myself as the primary analyst could not prevent my subjectivity from creeping into the analysis, to the detriment of the study. An alternative to this approach is to insist on group consensus in the generation of categories (e.g., Rhodes, Hill, Thompson, & Elliott, 1993). However, it can also be argued that the core of human science lies in its subjectivity and that good human science is subjectivity kept within the boundary of critical realism (Maxwell, 1992; Rennie, 1993). Furthermore, in terms of intersubjective agreement on categories, it can be maintained that certain sublettes of the phenomenon may be lost during the task of conceptualization by committee, and that there is no substitute for the sensitivity of the expert working alone (see Giorgi, 1989). Ultimately, this debate reduces to the question of the extent to which human science is an objectivistic or a constructionistic endeavor.

The Brown and Levinson Model

As indicated earlier, the Brown and Levinson (1987) model of politeness is a useful framework for understanding the social interactional dynamics leading to the properties of client’s deference. The therapy relationship is formal, and hence distant. It is asymmetrical, with most of the power being invested in the therapist. Finally, it is very important; clients evidently fear that poor management of the therapist’s face may result in severe consequences. Thus, the summation of these three components of the degree of threat associated with anticipated face-threatening acts is very high. It is not surprising that the clients in this study chose to withhold comment as their preferred deferential strategy.

The results of this study expand the Brown and Levinson (1987) model by illustrating that it applies equally well to the language of unexpressed thought. Hence, as an amendment to their comment about the uninterestingness of silence as a politeness strategy, it can now be observed that deferential silence is highly pertinent to that model, provided the reasons for the silence are accessed.
**Client’s Covert Processes**

A number of studies have recently contributed to an understanding of the client’s covert experience while in therapy (e.g., Angus & Rennie, 1989; Elliott & Shapiro, 1992; Hill, 1989; Hill, Helms, Spiegel, & Tichenor, 1988; Hill, Thompson, & Corbett, 1992; Regan & Hill, 1992; Rennie, 1990, 1992, 1994a, 1994b; Shaul, 1993; Thompson & Hill, 1991; Watson & Rennie, 1994). Among these investigations, my program and that of Hill and her associates have been similar in that both, at a minimum, have involved the study of the experience of entire therapy sessions. However, the programs have also differed fundamentally in that the former involved the human science approach whereas the latter entailed the natural science approach. This difference makes it difficult to compare the returns from the two programs; even so, there appears to be some convergence. In their earlier work, based on brief therapy with screened, volunteer clients, Hill and her co-workers found that it was mainly negative reactions that were withheld. However, more recently, they studied clients’ experience of long-term therapy with highly experienced therapists and found that thoughts and feelings about the therapeutic task were also, at times, not disclosed to the therapist (Hill et al., 1993). This last result ties in with the finding in my program that clients may choose not to disclose any thought or feeling, negative or otherwise, depending on the contingencies of the moment.

In terms of the content of unspoken, negative reactions, Hill et al. (1988) initially developed, through a rational analysis supported by statistical techniques, the Client Reactions System of 21 client reactions grouped into five clusters, including a negative reaction cluster. In the main, the individual reactions in the negative cluster appear more egocentric than interpersonal and hence tend not to address the client’s deference as conceptualized in the present article (although two exceptions appear to be lack direction and misunderstood). Also, because the use of the Client Reactions System involves having clients listen to and watch a videotape replay of their therapy session and simply choose which reaction clusters apply to each unit of analysis, the clients’ reasons for not revealing the reaction to the therapist are not given. This research design also mitigates the identification of categories of experience bearing on clients’ deference. In the Hill et al. (1993) study, however, two other clusters of categories representing covert thoughts and feelings—things left unsaid and secrets—were used in addition to the categories in the Client Reactions System. Furthermore, an inquiry was made into the reasons for silence, a content analysis of which gave rise to seven categories. Four of them (therapist wouldn’t understand, therapist didn’t ask or didn’t seem interested, client was unsure about feelings, and client trusted therapist to ask important things) appear closely related to the categories of client’s deference conceptualized in this study. This relationship seems even more compelling when, in illustrating their categories, Hill and her colleagues (1993) gave the following quotations from their respondents: “‘When we spoke about my husband, she made me feel like I was wrong and bad to him’; ‘I felt unsupported in talking about possible hospitalization’; ‘I felt afraid of hurting his feelings’; ‘Frustration and anger that he was trying to change the feelings I have inside about death’” (p. 285). These quotations variously appear to illustrate concern about the therapist’s approach and fear of criticizing the therapist—properties of client’s deference.

**Implications of Client’s Deference for Therapeutic Practice**

The foregoing understanding of client’s deference leads to the implication that attempts by therapists to recognize and deal with clients’ unspoken appraisals, especially when negative, might strengthen the working alliance and, possibly, improve the outcome of therapy. However, several studies have provided an indication that therapists’ awareness of negative client reactions is negatively associated with outcome (Fuller & Hill, 1985; Martin, Martin, Meyer, & Slemomon, 1986; Martin, Martin, & Slemomon, 1987), although this finding has been challenged (Hill et al., 1993; Horvath, Marx, & Kamann, 1990). Among the suggestions advanced to explain the negative relationship between therapists’ awareness of client negativity and outcome is that therapists’ awareness may draw clients’ attention away from themselves and that, on the other side, therapists’ awareness may undermine their own self-confidence and performance. Hill et al. (1993) suggested that the relatively more experienced therapists in their study may have been able to deal more effectively with their awareness of their clients’ negative reactions.

These findings and speculations can be articulated with results of my research program indicating that clients are mainly interested in focusing on themselves and feel that they have to tear themselves away from their self-focus when the therapist’s response is disjunctive with it (Rennie, 1990). As seen in the present article, however, it is also evident that clients’ concern about the therapist’s way of being and performance may make it difficult for them to maintain self-focus. In this state, clients might prefer that the therapist make an inquiry into their inner discomfort. The strength of clients’ deference implies that it is up to the therapist to take this initiative. Indeed, the reasons for the deference may be so well disguised as to make it difficult for the therapist to realize the extent of the client’s distress. This being the case, there is no substitute for the therapist’s sensitivity and judgment.

In conclusion, with regard to the traditional aspects of the relationship with the therapist, the client’s deference appears to have the most direct implications for the working alliance and, in a related way, for the client’s resistance (Rennie, 1994a). Being deferential to the therapist is the client’s way of protecting and fostering the alliance. However, deference may at times be costly in terms of both energy and commitment to the therapist’s plans and expectations. Even so, whether clients would welcome either an invitation to express inner discontent or the therapist’s disclosure of intentionality depends on the extent to which the discontent becomes disruptive of their ability to focus pro-
ductively on themselves. The knowledge that clients are extremely inclined to be deferential to them might augment therapists' sensitivity and clinical judgment in helping them to make this assessment.

References


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