COLLABORATIVE THERAPY: PERFORMING SPONTANEOUSLY, CREATIVELY AND COMPETENTLY[i]

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"*How can our therapy have relevance for people's everyday lives in our fast changing world, what is this relevance, and who determines it?*" is a persistent question for collaborative therapists and a question that I think all therapists should be asking. Why?

We live in such a fast-changing world that is characterized by global and local shift--social, cultural, political, and economic transformations as well as the influence of the internet and media on the decentralization of information, knowledge, and expertise. Equally important, there is an international spotlight on democracy, social justice, and human rights; the importance of the people's voice, singular or plural; and the need for collaboration. People around the world increasingly want input into what affects their lives; they have lost faith in rigid institutions and therapys in which being treated as numbers and categories ignores their humanity or worse yet, violently violates it. They demand systems and services that are more flexible and respectful. These shifts, the unavoidable complexities inherent in them, and the effects they have on our individual and communal lives and on our world press therapists to reassess how we understand the world around us, our clients, and our roles as therapists. Collaborative therapy is a response that shares common ground with a growing international community of therapists and clinical scholars including Tom Andersen, Vivien Burr, John Cromby, Kenneth Gergen, Mary Gergen, Lynn Hoffman, Lois Holzman, Lois Shawver, Imelda McCarthy, Susan McDaniel, Sheila McNamee, Greg Neimeyer, Robert Neimeyer, David Nightingale, Peggy Penn, Sallyann Roth, Jaakko Seikkula, John Shotter, Lois Shawver, and Michael White, and their colleagues. Though this article focuses on therapy, the assumptions on which it is based have applicability across

disciplines and practices, and across a variety of human systems regardless of the designated system, the number of people in it, or their relationship with each other—this includes systems such as education, research and combinations of people called organizations and communities (Anderson & Goolishian, 1988; Anderson, 1997; Anderson & Gehart, 2006).

Though Collaborative Therapy and other approaches sometimes referred to as dialogical therapy, conversational therapy, open dialogue, and reflecting process therapy are often seen as new approaches to therapy, the assumptions about knowledge and language that they draw from have been present within philosophical discourses since the eighteenth century beginning with the historian Giambattista Vico's notion that the observer is part of the description. Other seminal authors in this philosophical movement include Mikhail Bakhtin, Jacques Derrida, Hans George Gadamer Jean Francois Lyotard, Richard Rorty, Lev Vygotsky, and Ludwig Wittgenstein, to mention a few. In psychology, similar assumptions were introduced with George Kelley's personal construct theory and other constructivists who disclaim a tangible, external reality. This direction in family therapy was strongly influenced by Gregory Bateson and his Palo Alto, California colleagues, along with others such as Humberto Maturana, Heinz von Foerster, and Ernst von Glasersfeld: all challenge us to leave our current "thinking boxes" and to change the way that we "see" things and consequently our "way of being."

Collaborative Therapy as presented in this article has evolved over time with its roots tracing back to the 1950's Multiple Impact Therapy project in Galveston, Texas (MacGregor, Ritchie, Serrano, McDanald & Goolishian, 1964). Its evolution over the years has been continually influenced by the reflexive nature of theory and therapy (Anderson, Goolishian, Pulliam & Winderman, 1986; Anderson & Goolishian, 1988, 1992; Anderson, 1997, 2006). Because a large percentage of the Galveston team's clinical and consultation therapy then--and

that of the Houston Galveston Institute afterwards--included a large percentage of people who are commonly called "treatment failures," we have continued to seek out how our therapy could have more relevant and effectiveness for these people. This ambition and curiosity have led to lessons learned from over 25 years of inquiry into client's experiences, and descriptions of the nature of successful and unsuccessful therapy and the advice that clients—the true experts--have for therapists (Anderson, 1996, 1997; Anderson & Goolishian, 1992).[ii] As well, we have been led to a therapy that is more spontaneous, flexible, and fitting to the uniqueness of each client that we meet and to their novel circumstances.

Assumptions of Collaborative Therapy: A Postmodern Tapestry

"Your attitude towards your life will be different according to which understanding you have."

Suzuki

Collaborative Therapy—sometimes referred to as postmodern, social construction, dialogical, or conversational therapy--has grown from assumptions in the broader postmodern movement in the social and human sciences, as well as from related assumptions from social construction and dialogue theories (Bahktin, 1981, 1984; Derrida, Edwards, 2005; Gadamer, 1975; Gergen, 1999; Hacking, 1999; Lyotard, 1984; Shotter, 1984, 2005, 2006; Vygotsky, 1986; Wittgenstein, 19). These assumptions inform the way the therapist conceptualizes and approaches therapy and have relevancy regardless of the designated system or the number of people involved in it.

I do not use a single definition of postmodern, instead I refer to a set of abstract assumptions that I think of as a "postmodern tapestry." These assumptions—the threads of tapestry--challenge our inherited traditions of knowledge and language, and provide a contemporary alternative. The central challenge is to reexamine these traditions of knowledge as

fundamental and definitive, the top-down nature of knowledge systems, language as descriptive and representational, and the stability of meaning. Following, I discuss seven assumptions of a postmodern tapestry.

1. Maintaining skepticism

Postmodernism asserts the importance of holding a critical and questioning attitude about knowledge as somehow fundamental and definitive. This includes knowledge of inherited and established dominant discourses, meta-narratives, universal truths, or rules. We are born, live, and are educated within knowledge traditions that we mostly take for granted. A postmodern perspective suggests that unwittingly buying into and reproducing institutionalized knowledge can lead to forms of therapy that risk being out of sync with our contemporary societies and possibly alien to humanity as well. This is not to suggest that we abandon our inherited knowledge or discourses (i.e., psychological theories, a priori criteria), or that these can be discarded for that matter. Any and all knowledge can be useful. Nor is it suggested that postmodernism is a meta-knowledge narrative. The invitation is simply to question any discourse's claim to truth, including the postmodern discourse itself. And, hopefully, to minimize the risk that we carry our knowledge errors forward.

2. Eluding generalization

The probability that dominant discourses, meta-narratives, and universal truths can be generalized and applied across all peoples, cultures, situations, or problems is suspect. Thinking in terms of ahead-of-time knowledge (i.e., theoretical scripts, predetermined rules) can create categories, types, and classes (i.e., people, problems, solutions) that inhibit our ability to learn about the uniqueness and novelty of each person or group of people. Instead, we might learn about the distinctiveness of others and their lives directly from them and see the familiar or what

we take for granted in an unfamiliar or fresh way. We are accustomed to viewing, wittingly or unwittingly, many people and the events of their lives encountered in therapy as familiar rather than exceptional. Familiarity tempts us to fill in the gaps and proceed based on our pre-assumptions about what is in these gaps; this knowing can put us at risk of depersonalizing the client and preventing us from learning about their specialness—limiting our and the client's possibilities.

3. Knowledge as an interactive social process

Embedded as it is in culture, history, and language, knowledge is a product of social discourse. The creation of knowledge (i.e., theories, ideas, truths, beliefs, or how to) is an interactive interpretive process in which all parties contribute to its creation, sustainability, and change. Knowledge is not fundamental or definitive; it is not fixed or discovered. Instead, it is fluid and changeable. So, instructive interaction is not possible; knowledge cannot literally be transmitted from the head of one person to another. Knowledge transforms as we share it with each other, in our interactions with each other, and in the dynamics of the relationship be that a relationship with an author on the pages of a book or with a teacher at the head of a classroom.

4. Privileging local knowledge

Local knowledge–the knowledge, expertise, truths, values, conventions, narratives, etc.--that is created within a community of persons (i.e., family, classroom, board room) who have first-hand knowledge (i.e. unique meanings and understandings from personal experience) of themselves and their situation is important. Since knowledge is formulated within a community it will have more relevance, be more pragmatic, and be more sustainable. Local knowledge, of course, always develops against the background of dominant discourses, meta-narratives, and

universal truths and is influenced by these conditions. This cannot be, nor is it suggested that it should be, avoided.

5. Language as a creative social process

Language in its broadest sense--any means by which we try to communicate, articulate, or express with ourselves and with others--is the medium through which we create knowledge. Language, like knowledge, is viewed as active and creative rather than as static and representational. Words for instance are not meaning-mirrors; they gain meaning as we use them and in the way that we use them. This includes a number of things such as context, why we use them, and how we use them such as our tone, our glances, and our gestures. Language and words are relational. As Bakhtin (1984) suggests, "No utterance in general can be attributed to the speaker exclusively; it is the *product of the interaction of the interlocutors*, and broadly speaking, the product of the whole complex *social situation* in which it has occurred" (p. 30). He further suggests that we do not own our words:

> The word in language is half someone else's. The word becomes "one's own" only when the speaker populates it with his own intention. . . the word does not exist in a neutral and impersonal language . . . but it exists in other people's mouths, in other people's contexts (1984, p. 293-4).

6. Knowledge and language as transforming

Knowledge and language are relational and generative, and therefore intrinsically transforming. Transformation—whether in the form of a shift, modification, difference, movement, clarity, etc.--is inherent in the fluid and creative aspects of knowledge and language. That is, when engaged in the use of language and in the creation of knowledge one is involved in a living activity—dialogue with oneself or another—and cannot remain unchanged.

7. Postmodern is only one of many narratives

The postmodern tapestry and its assumptions are considered as one of many narratives. Postmodernism is not a meta-narrataive or –perspective as self-critique is inherit in and essential to postmodernism itself. This does not suggest, therefore, that postmodernism is an oppositional perspective that calls for the abandonment of our inherited knowledge or any discourse, or that these can be discarded for that matter. Postmodern assumptions simply offer a different language or set of assumptions, or as Wittgenstein suggests, a different language game (Amscombe & Amscombe, 2001). I ask, "*What are the implications of this different language or language game? How does it influence the way that I think about the process and goals of therapy,, including the client's role and my role in these*?"

Implications for Clinical Therapy: Collaborative Relationship and Dialogical Conversation

"All understanding is dialogical."

Bahktin

Intrinsically related positions and processes, *collaborative relationships* and *dialogical conversations* establish the cornerstone of clinical therapy based in the above assumptions. *Collaborative relationship* refers to the way in which we orient ourselves to be, act, and respond "with" another person so the other joins a therapeutic shared engagement and joint action that I call a shared inquiry (I discuss shared inquiry later in this article). Shotter (1984) earlier suggests that all living beings exist in joint action--in the meeting and interacting with one another in mutually responsive ways. That is, we are relational beings who mutually influence and are mutually influenced by each other. As relational beings our "selves" cannot be separated from the relationship systems which we are, have been, and will be a part of. As well, though we are

always speaking an ambiguous and different language than the other, as Bahktin (1981) suggests, our speaking and our language always includes others' intentions and meanings.

Here I want to highlight "respond." We are always responding: there is no such thing as a "no response" or "lack of response." There is simply one kind of response which as with any response, the "receiver" interprets and decides whether this action is hearable or visible or not. Our responses to the other are critical to the development and quality of the relationship. They create the framework, the parameter, and the opportunity for the relationship will and will not be. Collaborative therapists value partnerships characterized by joint action or social activity in which each member develops a sense of participation, belonging, and ownership. With these come a sense of commitment and shared responsibility. The therapist is the catalyst for this partnership and its process. I am talking about the therapist's response to the client, yet, of course, responding is an interactive two-way process.

Dialogical conversation refers to talk in which participants engage "with" each other (out loud) and "with" themselves (silently) in a mutual or shared inquiry: jointly responding (i.e., commenting, examining, questioning, wondering, reflecting, nodding, gazing, etc.) as they talk about the issues at hand. By talk I mean any way in which we communicate, express and articulate such as in words, signs, symbols, gestures, sighs, etc. Drawing on Bakhtin's (1984) definition, dialogue is a form of verbal interaction; it is communication between people that takes place in the form of an exchange of utterances. Important to highlight, dialogue, however, is not limited to spoken words; it also includes the silent way (e.g., inner talk and bodily expression) in which we talk with ourselves and others.

Dialogue involves a process of trying to understand the other person from their perspective not ours. Dialogical understanding is not a search for facts or details but an

orientation. It is an (inter)active process not a passive one that requires participation through responding to connect and learn about the other from them, rather than to pre-know and understand them and their words from a theory. In relation to therapy, dialogue is invited through the process of the therapist's learning about the other, especially about their uniqueness and noticing the not-yet-noticed. The uniqueness and the not-yet-noticed can be thought of as those things that are before our "eyes" that we often do not see or see differently because we are seduced to see what we expect to see or know that we will see ahead of time. Through the process of trying to understand, local understandings develop from within the conversation. Dialogue is an always becoming, never-ending, and immeasurable process. As Bakhtin (1981) said, dialogue is the condition for the emergence of new meaning and other newness.

In my experience, when people have a space and process for collaborative relationships and dialogic conversations, they begin to talk with themselves, each other, and others in a new way. Through these conversations differences develop that can be expressed in an infinite variety of forms such as enhanced self-agency and freeing self-identities, different ways to understand themselves, their life events and the people in their lives as well as new options to respond to the challenges and dilemmas of the circumstances and situations in their lives.

I ask, "*How can therapists invite and facilitate the conditions and the metaphorical space for collaborative relationships and dialogical conversations?*" I turn to the philosophical stance.

The Philosophical Stance: A *Way of Being*

". . . not to solve what had been seen as a problem, but to develop from our new reactions new socially intelligible ways forward, in which the old problems become irrelevant."

Shotter

"Problems are not solved but dissolved in language."

Anderson & Goolishian

The philosophical stance is *the heart and spirit* of the collaborative approach and refers to the way that we approach our therapy practice and the people we meet in it. It refers to an attitude, a posture and a tone that communicates to another the special importance that they hold for me, that they are a unique human being and not a category of people, and that they are recognized and appreciated, and that their voices are worthy of hearing. It refers to a posture of meeting each person and their circumstances as if we have not met them before. It reflects a way of being *with* people, including ways of orienting with, thinking with, talking with, acting with, and responding with them. The significant word here is *with*: a "withness" process of orienting and re-orienting oneself to the other person (Hoffman, 2007; Shotter, 2004, 2005). Influenced by Shotter's notion of "withness thinking", Hoffman (2007) refers to this kind of relationship "withness" as "one that is as communal and collective as it is intimate, withness that requires us to "… jump, like Alice, into the pool of tears with the other creatures. Withness therapy relationships and conversations become more participatory and mutual and less hierarchical and dualistic. Such relationships and conversations invite and encourage the other to participate on a more equitable basis.

The philosophical stance expresses the assumptions of collaborative therapy. It has seven distinctive, interrelated, features that are guiding ideas that the therapist values and is sensitive to; together they affect how the therapist thinks about and performs the relationship and the conversation with the client, and helps create and foster the conditions and space for these.

It serves as a conceptual sensitivity[iii] that allows a therapist to be creatively inventive and customize therapy for each client. In other words, though the stance has common identifiable features, their expression is unique to each therapist, each client, and each human system and to the circumstances and desires of each. Important, despite guiding ideas Collaborative Therapy is

not formulaic or recipe-like. Nor is the philosophical stance a technique or set of techniques. It acts as a philosophical orientation, not as a method that is determined ahead of time and used repeatedly.

Next, I will discuss seven inseparable conceptual guides that influence the therapist and the therapy process. A note: by guides, I do not mean to imply that lead

1. Mutually Inquiring Conversational Partnership.

Attracting and engaging the other into a collaborative relationship and dialogic conversation entails inviting them through the therapist's way of being, a way that communicates to the client, as mentioned above, that they and their situation hold a special importance for the therapist, that their views are respected, and that what they have to say is valued without judgment. This begins a partnership relationship and process characterized by a joint activity that I refer to as "shared" or mutual inquiry. It is an in-there-together process in which two or more people (one of whom can be your self) put their heads together to puzzle over and address something. In other words, the other is not an object of study, but a subject of study and so a subject-subject mutual study or inquiry.

The therapist invites the client into this mutual inquiry by taking a learning position through: a) making room for and giving the client the choice to tell their story in their own manner and at their own pace; b) being genuinely interested and curious about the client's story; c) listening and responding attentively and carefully; d) responding to better understand the client's perspective or sense-making map; e)trying to respond to what the client is saying (not what the therapist thinks they should be saying); f) noticing how the other person responds before continuing; g) paying attention to their words and their non-words; h) checking-out through comments, questions, and alternative words if you have heard what the other wants you to hear;

i) pausing and allowing silences for listening and reflecting spaces; and j) allowing each person to choose to respond to what peaks his/her interest and in their own way. I use two metaphors with my students to help them learn how to invite another into collaborative relationships and dialogical conversations, and thus a mutual inquiry.

As Derrida (Bennington, 2003) suggests, an invitation requires unconditional hospitality. I find a host/guest metaphor helps to highlight the importance of unconditional hospitality as well as the subtleties and nuances of greetings and meetings and how they begin to shape the tone and, quality of the relationship and the conversation, and consequently their potential (Anderson, 1997; Anderson & Gehart, 2006). I emphasize that the therapist is the host and at the same time is a guest in the client's life.

> . . . it is as if the therapist is a host who meets and greets the client as a guest while simultaneously the therapist is a guest in the client's life. I ask my students to think about how they like to be received as a guest. What does the host do that makes them feel welcomed or not, at ease or not, and special or not? What did the quality of the meeting and greeting feel like? These are not rhetorical questions. I do not expect specific answers. Instead, I want the students to think about the sense of their experience in the relationship and conversation and what it communicated to them (Anderson, 2006, p. 45)

I also use a "storyball" metaphor to discuss the learning position and mutual inquiry with my students. When I first meet a client and they begin to talk, it's as if they gesture to hand me a gift -- a storyball of intertwined threads of their life narratives and their current circumstance. I respond (Anderson, 2006):

> As they put the ball toward me, and while their hands are still on it, I gently place my hands on it but I do not take it from them. I begin to participate with them in the story telling, as I slowly look at/listen to the aspect that they are showing me. I try to learn about and understand their story by responding to them: I am curious, I pose questions, I make comments, and I gesture. In my experience, I find that this therapist learning position acts to spontaneously engage the client as a colearner; it is as if the therapist's curiosity is

> contagious. In other words, what begins as one-way learning becomes a two-way, back-and-forth process of mutual learning as client and therapist coexplore the familiar and codevelop the new, shifting to a mutual inquiry of examining, questioning, wondering, and reflecting with each other (p. 47).

My responses—whatever form they may take, whether questions, comments, gestures, glances, etc—are informed by and come from inside the conversation itself; that is, they relate to what the client has just said or done. They are not informed by my "truth" about the client: what I think the client should be talking about, is really thinking, or should be doing. My responses are my way of participating in the conversation from a continually learning position and to ensure that I understand as best I can: all to encourage the back-and forth process that I call mutual inquiry and to engage the client in a new curiosity about themselves. Through the process of mutual inquiry the client begins to develop meanings for themselves and the people and events in their lives that permit addressing the circumstances in their lives for which they sought consultation, as well as other possibilities with far reaching effects. In other words, the newness comes from within the dialogical process. These possibilities or the newness, as mentioned above, may take infinite forms.

Through this joint activity, the client-therapist relationship and conversation begin to determine the process or method of inquiry; the process or method does not define the relationship and the conversation. That is, client and therapist create from within the present relationship and conversation in the moment as each moment unfolds, not from outside it or ahead of time. The therapist does not control the direction of the conversation or storytelling but participates in it. Together, client and therapist shape the story-telling, the re-telling, and the new telling yielding a richness of novel freshly seen possibilities and previously unimagined futures.

When working with a family I think of each member as coming with his or her own storyball. I want to make room for and show the importance I place on each one. It is not unusual

for members to have different and sometimes competing story versions. These are part of the collective storytelling. I am interested in understanding each version; I do not strive for consensus. I have found that the differences are important and that possibilities emerge from these differences as we engage with each other in the tellings and re-tellings.

Regardless of the number of people in the therapy room, an in-there-together connection and activity begins in which people talk with, not to, for, or about each other. Each member develops a sense of *belonging* which invites *participation*, which in turn invites *ownership* and a sense of *commitment* and *shared responsibility*.

I tend to talk with one person at a time, listening intensely to their story, and conveying with words and actions the importance for me of what they are saying. I respond with questions, comments, etc. that are informed by what they have just said not by what I think they should be saying. In my response to the client and theirs to mine, meanings and understandings begin to be clarified, expanded, and altered. As one member of a family talks and the others listen, all parties begin to experience a difference in the story tellings and re-tellings. When a speaker has the room to fully express him or herself without interruption and the others have equally full room for listening, all begin to have a different experience of each other and what is said and heard. When you are able to fully listen without preparing your response or sitting on the edge of your chair preparing a corrective response, you begin to hear and understand things in other ways.

I would like to make a few comments about questions. I do not think of questions as posed for answers, or to collect data of information. I think of questions as starting points for dialogue and for facilitating continued conversation, as expressing curiosity and interest, and as breathing life and energy into a conversation.

2. Relational Expertise

Both client and therapist bring expertise to the encounter: The client is an expert on themselves: their life, their world, their "problem" and its "solution." The therapist is an expert on a process and space for collaborative relationships and dialogical conversations. The focus on the expertise of the client does not deny the expertise of the therapist: It calls our attention to the client's wealth of know-how on his or her life and cautions us not to value, privilege, and worship the therapist as a better knower than the client. The therapist's expertise is in helping the other do it themselves; the therapist's expertise is always present but not in an hierarchical fashion. Again, I do not suggest that the therapist lacks or pretends a lack of expertise. Of course, therapists have expertise, though from a collaborative perspective it is a different kind of expertise: it is a "know-how" in inviting and maintaining a space and process for collaborative relationships and dialogical conversations. The risk of ay kind of therapist expertise, or outside knowledge, is that we bring and carry our pre-understandings forward. The collaborative therapist is always prejudiced by their experiences, but they try to listen in such a way that their pre-experience does not close them off to learning and responding to understand the full meaning of the client's descriptions of their experiences.

3. Not-Knowing

Not-knowing refers to how a therapist thinks about the construction of knowledge and the intent and manner with which it is introduced into the therapy. It is a humble attitude about what the therapist thinks he/she might know and a belief that the therapist does not have access to privileged information, can never fully understand another person, and always needs to learn more about what has been said or not said.

A collaborative therapist keeps the emphasis on knowing *"with"* another instead of knowing another person, their circumstances, or the preferred outcome better than the person or

beforehand. A collaborative therapist is aware of the risk that these knowings can place people in problem categories or identify them as members of a type of person. Such knowing can interfere with the therapist's ability to be interested in and learn about the uniqueness of that person and the novelty of their life. Knowing *"with"* is crucial to the dialogical process.

A not-knowing position does not mean the therapist does not know anything or can discard or not use what she or he knows (i.e., theoretical knowledge, clinical experience, life experience). Rather, the emphasis is on the intent, the manner, and timing with which the therapist's knowing is introduced. The introduction of a therapist's knowledge is simply a way of participating in the conversation, offering food for thought and dialogue, and offering a way to continue to talk about what is already being addressed. Following the client's response, including being able to let go if the client is not interested, and refraining from private interpretations regarding the response, is important.

4. Being Public

Therapists also have private thoughts —whether in the form of professionally, personally, theoretically, or experientially informed understandings (i.e., such as diagnoses, judgments, or hypotheses). These thoughts influence how the therapist listens and hears and inform the therapist's responses. From a collaborative stance, the therapist is open and generous with their invisible thoughts, making them visible or what I call *being public.* Being public does not refer to what we traditionally think of as self-disclosure. Instead it has to do with the inner conversations that therapists have with themselves about the client and the therapy. Being public is offering food for thought and dialogue, putting forward possibilities of things to talk about or ways to talk about them. It is one way for the therapist to contribute to the conversation. I want to highlight

the notion of "participate;" the intent is to *take part in* an unbiased manner and not to unduly steer the conversation nor tenaciously promote an idea or opinion.

When talking about their experiences of successful and unsuccessful therapy, I have consistently heard clients comment that they always wondered what the therapist really thought of them. They always wondered what was "behind" the therapist's questions. They felt that there was a private conversation about them that they were not part of.

Elsewhere I have articulated two grounds for making private thoughts public (Anderson, 2006).

One,

> Making private thoughts public invites what Bahktin (1981) refers to as responsive understanding. He suggests that, "A passive understanding of linguistic meaning is not understanding at all" (p. 281). Shotter, influenced by Wittgenstein, suggests a relational-responsive kind of understanding. In other words, understanding cannot take place unless both the speaker-listener and the listener-speaker are responsive to each other. An unresponsive inner conversation is in danger of leading to missed-understanding or understanding that does not fit with that of the speaker or their intent (e.g., the client's).

And two,

> Putting private inner talk or thoughts into spoken words produces something other than the thought or understanding itself. The expression of the thought organizes and re-forms it; therefore, it is altered in the process of articulation. The presence of the client and the context along with other things, affects the words chosen and the manner in which they are presented. As well, the client then has the opportunity to respond to the therapist's inner thought. The response—in the many forms that it may take such as expressing interest, confirming, questioning, or disregarding—will affect it.

Both put the therapist at risk for their inner talk becoming monological and contributing to the creation or maintenance of therapist-client monologue. By monologue I mean the same thought, like a tune in one's head that plays over and over again. When this happens therapist and client side-by-side each sing their monological tunes and the conversation breaks down.

5. Living with Uncertainty

Therapy conversations are more like natural talk in which each person's response informs and invites the other's. The conversations are not guided by structured maps as to how the conversation should look or unfold; for instance, the pace or the sequence of what is talked about. Nor are they guided by pre-structured questions or other strategies. Conversations are a spontaneous activity in which client and therapist together create the paths and determine the destination. What is created is different from and more than what could have been created by one without the other. (This is discussed more fully later in this article).

When client and therapist engage in this kind of spontaneous endeavor, there is always an uncertainty about where they are headed and how they will get there. This does not ignore that clients may come in with a pre-defined problem and a destination as well as expectations about how you will help them. They often do. It is not unlikely however that that these will change through the course of the therapy conversations. As conversational partners, client and therapist coordinate their actions as they respond, making their path and destination unpredictable. What the path looks like, the detours along the way, and the final destination will vary from client to client, from therapist to therapist, and from situation to situation.

Put another way, no one knows how a story will unfold, how newness in it will emerge, or what the newness will look like when engaged in a collaborative relationship and dialogical conversation. Though, of course, there is nothing wrong with having an idea and comfort about where you are headed and how you will get there, surprises in the endless shifts and possibilities (i.e., thoughts, actions, meanings) of conversations emerge from the process. Trusting uncertainty involves taking a risk, living with the sometimes associated tension, and being open to unforeseen change.

6. Mutually Transforming

I have been trying to stress the mutuality of the therapy encounter. In this kind of *withness* relational process, each party is under the influence of the other(s) and hence each party, including the therapist is as much at-risk for change as any other. It is not a one-sided, unilateral therapist-driven process, nor is the therapist passive and receptive. The therapist is actively involved in a complex interactive process of continuous response with the client, as well as with his/her own inner talk and experience. In other words, as conversational partners we continually coordinate our actions with each other as we respond with each other. And, we are each continuously influenced by the other. Therapy is an active process for both the client and the therapist.

7. Orienting towards Everyday Ordinary Life

Over my years of practicing, teaching, and consulting in various contexts and countries I began to think of therapy, like all of life, as one kind of social event. Though it takes place in a particular context with a particular agenda, therapy does not need to be a sacred event with high priests and commoners. It can resemble the way we interact and talk in everyday life or the "naturally occurring interactional talk . . . through which people live their lives and conduct their everyday business" (Edwards, 2005, p. 257). As in everyday life as Wittgenstein suggests, we search for how to know our "way about" and how to "go on." In therapy, participants strive for ways to move forward and carry on with their lives.

I have found it helpful to have a positive outlook regarding the people who consult me regardless of their histories and circumstances. This includes a belief that humans are naturally resilient and desire healthy relationships and qualities of life. I have also found it helpful not to be constrained by discourses of pathology and dysfunction. As I mentioned earlier, I do not think in terms of categories of people or kinds of problems, though of course I could find similarities

across-the-board if I looked for them. This does not mean that I think diagnoses, for instance, should be thrown out the window, but rather I keep in mind that diagnoses, like other deficit discourses, can pose limits to possibilities if we only see the diagnosis and not the unique person. Instead, I have found it helpful to create more conventional frameworks of understanding *with* my clients that are less confining, more likely to yield a increased sense of personal agency, and more likely to hold the promise of different futures. I think of each person and each family I meet as one I have not met before. I am in interested in learning about them and their distinctive circumstances from their perspective and creating with them a unique response to what they are seeking consultation about.

Possibility Futures

In conclusion, if a therapist assumes a philosophical stance such I am describing, they will naturally and spontaneously create a space that invites and encourages conversations and relationships in which clients and therapists "connect, collaborate, and construct" with each other (Anderson, 1992, 1997). And, where each member will have a sense of participation, belonging, and ownership: all combine to promote effective outcomes and their sustainability. Because the philosophical stance becomes a natural and spontaneous way of being as a therapist, theory is not put into therapy and therapists do not employ techniques and skills as we usually think of them. Instead, the stance flows from a set of philosophical assumptions that inform a *way of being* in relationships and conversations that are collaborative and dialogical. In other words, the philosophical stance *is* a way of being, an attitude that, as suggested above, sets the "tone" for the way in which we orient ourselves to be, respond, and act *with* another person. It invites the other into shared engagement, mutual inquiry, and joint action—the process of generative and transforming dialogue (Anderson, 1997, 2003)—making

collaborative therapy and other collaborative endeavors *withness insider* therapys with possibility futures.

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Endnote

[1]In discussing Wittgenstein's language game psychologist Lois Shawver (http://users.california.com/~rathbone/word.htm) quotes him, ". . . the term 'language game' is meant to bring into prominence the fact that the 'speaking' of language is part of an activity, or form of life." Continuing, she suggests that language game "refers to models of primitive language that Wittgenstein invents to clarify the working of language in general. . . .The idea is that if we think in terms of language games, that is, if we ask how our language games are taught and how they are used, then we will begin to see past certain myths in our culture that trap us in misleading pictures of language processes and communication. Getting past these pictures will enable us to see human psychology with fresh eyes, but what we see with fresh eyes is not predetermined. Wittgenstein does not tell us what we will see. He simply helps us see past these ancient pictures because, quoting Wittgenstein, "A 'picture' held us captive. And we could not get outside it, for it lay in our language and language seemed to repeat it to us inexorably.

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[i] An earlier version of this article appears in *The Blackwell Handbook of Family Psychology* (2009) M. Stanton & J. Bray (Eds.). New York: Wiley-Blackwell.

[ii] For detailed descriptions of what we learned from clients and the shifts in our clinical work, please see Anderson, 1997, chapters 3 and 7).s

[iii] I take this word from a presentation that John Shotter made in Mexico City in March 2008. It struck me as a much more fitting word than guide or others.