# CHAPTER 6

# POSTMODERN/POSTSTRUCTURALIST THERAPY [1]

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A new generation of therapies has been developing since the past quarter of the twentieth century. The proponents of these approaches questioned many of the premises that historically sustained psychotherapeutic practice, and they offered alternative ways of conceptualizing and doing therapy. This movement is not represented by a single school or model, but by the work of many theorists and practitioners who share some philosophical and epistemological common ground.

These therapies are variously called *postmodern, narrative, discursive, conversational, poststructuralist, collaborative,* and *social-constructionist.* The lack of one unifying name can be confusing, but each term highlights an important aspect of each approach: Discursive and conversational suggest that therapy is seen as a conversation and as a linguistic process. Narrative refers to a strong interest in the way people create meaning in their lives through stories or narrations of their experience. Social constructionist emphasizes that knowledge, meaning, and identity are constructed through interaction with others. Poststructuralist identifies therapists who don't think of human difficulties as manifestations of deep or underlying structures. Collaborative describes the kind of relationship that these therapists hope to establish with their clients and the process of therapy as a joint endeavor.

In this chapter, I have chosen the word *postmodern* because I believe, like Harlene Anderson (1997, 2006b), that it offers a broad philosophical umbrella that encompasses several different but connected schools of thought. The term *poststructuralist* is also included because it is the tradition in which the creators of narrative therapy prefer to locate their work.

This chapter discusses three schools or postmodern/poststructuralist therapies: (1) solution-focused therapy (SFT), represented by the work of Steve De Shazer and Insoo Kim Berg; (2) narrative therapy, created by Michael White and David Epston; and (3) collaborative therapy, developed by Harry Goolishian and Harlene Anderson. This is not an exhaustive list of postmodern/poststructuralist therapies. Anderson (2003b)

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acknowledges the important contributions of Lynn Hoffman, Peggy Penn, and Tom Andersen to the development of these approaches.

Collaborative therapy, SFT, and narrative therapy each have unique characteristics and specific ways of working. There are important differences between them, but they're frequently grouped together because they share certain basic premises about language, knowledge, interpersonal relationships, and identity (Anderson,2006, Paré & Tarragona, 2006).

An in-depth discussion of the postmodern critique is beyond the limits of this chapter. This chapter only describes some of the postmodern ideas that have had the greatest impact on psychotherapy and how they have been translated into therapeutic practice. It presents a brief overlook of the basic premises of narrative therapy, collaborative therapy, and SFT, as well as the main therapeutic practices of each of these models.

# Postmodernism, Poststructuralism, and Psychotherapy

The word *postmodern* is generally used to refer to at least three realms: (1) a historical era, (2) a movement in the arts, and (3) a critical movement in academia, particularly in social sciences and philosophy.

## *Postmodern Era*

The term *postmodernity* is used to refer to a cultural epoch or historical period (Grenz, 1996; Sarup, 1993). It would roughly correspond with a time beginning in the second half of the twentieth century to present day. Grenz (1996) describes the industrial age, often identified as the *modern era*, as a period centered on the production of goods and symbolized by the factory, whereas postmodernity is characterized by the production of information and can be represented by the computer.

Postmodernity is characterized by an unprecedented speed and ease in transportation and communications that leads to an interconnection between places, people, and cultures. We are exposed to many different descriptions of reality and different truths, to countless models or possible ways of being. In his book, *The Saturated Self,* Kenneth Gergen says, "New technologies make it possible to sustain relationships— directly or indirectly—with an ever expanding range of other persons. In many respects we are reaching what may be viewed as social saturation" (1990,p. 3). Gergen argues that

these technological developments and the social saturation that they create have a profound impact on our understanding of the self.

# *Postmodern Art*

Postmodernism has had an impact in the arts, including postmodern architecture, theatre, literature, painting, performance, and so on. Discussing postmodern artistic expressions in detail is beyond the scope of this chapter. Suffice to say that they are often characterized by deliberate juxtapositions of materials and styles and by an eclectic aesthetic, in contrast to the univalence and stylistic integrity characteristic on modern art. Postmodern artists frequently challenge cannons and institutions and blur the line between high art and popular culture (Grenz, 1996).

# *Postmodern Critique*

*Postmodernism* as an intellectual movement is the aspect of postmodernity that is most relevant for this chapter. Harlene Anderson (1997) considers that it's more important to think about postmodernism as a critique than as a historical period and emphasizes that postmodern refers to a philosophical movement that includes the ideas of many thinkers, like Mihail Bakhtin, Jacques Derrida, Michel Foucault, Jean-Francois Lyotard, Richard Rorty, and Ludwig Wittgenstein, among others. The postmodern critique, a movement that began in academe in the 1970s, questioned the nature of knowledge and *meta-narratives* or universal explanations. It was especially strong in the social sciences where it questioned the possibility of being objective observers of reality, particularly of the reality of human phenomena.

Several authors (Gergen, 1991, Grenz, 1996; Sarup, 1993; Shawver, 2005) suggest that to understand the postmodern, it is useful to contrast it with the modern, which refers to a worldview rooted in the Enlightment and prevalent in the Western world during most of the twentieth century. The industrial revolution brought a different form of production and one new invention after the other. During the twentieth century, radios, cars, telephones, television, airplanes, spaceships, and computers were all invented. Medicine advanced in giant leaps, improving the life expectancy and quality of life of millions in developed nations. Science and technology were seen as an unlimited source of hope for the future (Shawver, 2005). The promise of continuous progress is what Gergen (1991 ) describes as the "grand narrative of modernism": the idea that we are on a journey of ever-increasing improvement and achievement.

Gergen notes that the "social sciences" were developed in the twentieth century with the ideal of finding the rules that can explain and predict human behavior. Psychology was redefined as a science "and its participants adopted the methods, meta-theories and manners of the natural sciences" (1991, p. 30). One implication of this is the

belief that people, like the world, can be known though observation and examination because we can also get to know a "true and accessible" self (Gergen, 1991).

In sum, the modern perspective is grounded in a positivist epistemology that supposes the existence of a reality independent from the observer that we can access directly and know objectively. The modern ideal is that *truth* can be found through the scientific method. Grenz says, "the modern mind assumes that knowledge is certain, objective and good" (1996, p. 4). From this perspective, knowledge is seen as a reflection or a mirror of reality, and language is thought of as representational—its function is to give us a correct representation of the world (Anderson, 1997).

The term *postmodern* was used as early as the late nineteenth century and occasionally in the 1930s (Grenz, 1996; Shawver, 2005), but it did not gain force or acquire its current meaning until the 1970s. Jean Francois Lyotard (1984 ) provided a popular definition in his book *The Postmodern Condition:* "Simplifying to the extreme, I define postmodern as incredulity toward meta-narratives."(p.xxiv) Meta-narratives are generalized, universal theories or, as Shawver (2005, p. 75) explains, "the central assumption that a person makes which is never itself questioned."

According to Grenz (1996), postmodernism "marks the end of a single, universal worldview. The postmodern ethos resists unified, all-encompassing and universally valid explanations. It replaces these with a respect for difference and a celebration of the local and particular at the expense of the universal" (p. 12).

As a philosophical movement, postmodernism has questioned the nature of knowledge and has pointed out some of the limitations of positivist epistemology in the study and understanding of human experience. The postmodern perspective is different from the modern position in many ways. A postmodern view of knowledge proposes that it is socially constructed through language. It supposes that we cannot have a direct representation of the world, so we can only know it through our experience of it (Anderson, 1997, 2006a ). Anderson (2006a ) makes clear in her description of "socially constructed" knowledge that it refers to the *social knowledge* or the *meaning* that we give to events and experiences, not to scientific knowledge or knowledge of the physical world.

One perspective that informs the postmodern view is social constructionism, a theory that proposes that we are always looking at the world through some kind of lens—our theories, culture, historical moment, gender, and so on (Hoffman, 1990). Social constructionists say that we live in a world of symbols, in a social reality that to us seems natural and objective, but that is built jointly between many people (Truett Anderson, 1990).

Language is a central concept in the postmodern critique. One important idea is that language constitutes reality. The words we use do not simply reflect or express what we think or feel, but rather language configures our ideas and the meaning of our experiences. Hoyt (1998) points out that we know and understand through our language

systems. Language is more than a means to transmit information because it shapes our conscience and structures our reality. Harry Goolishian, one of the founders of collaborative therapy, used to say, "I never know what I mean until I say it" (Anderson, 2005, p. 4).

Harlene Anderson (1997) characterizes postmodern thought this way:

*Postmodern thought moves toward knowledge as a discursive practice, toward a plurality of narratives that are more local, contextual, and fluid; it moves toward a multiplicity of approaches to the analysis of subjects such as knowledge, truth, language, history, self, and power. It emphasizes the relational nature of knowledge and the generative nature of language. (p. 36)*

# *Poststructuralism*

Poststructuralism is a movement in philosophy, particularly in French philosophy. Belsey defines it as "a theory or group of theories, concerning the relationship between human beings, the world, and the practice of making and reproducing meanings" (Belsey, 2002, p. 5). Arising from literary theory, poststructuralism proposed that the meaning of a text is not *in* the text, inherent in what is written, but that meaning emerges or is produced as the reader interacts with the text (Grenz, 1996; Sarup, 1993). The leading poststructuralist thinkers are Derrida, Foucault, and Lacan (Sarup, 1993). A central concept in poststructuralism is *deconstruction,* a method of closely reading a text that allows us to see that no meaning is fixed. Grenz (1996) offers this explanation of deconstruction: "If language really does construct meaning (as opposed to revealing an objective meaning already present in the world), then the work of the scholar is to take apart ("deconstruct") this meaning constructing process" (p. 43).

The relationship between poststructuralism and postmodernism is not clear cut. For example, Grenz (1996) talks about Foucault and Derrida as postmodern philosophers, whereas Sarup (1993) mentions them as two leading poststructuralists. Harlene Anderson (1997) says that even though postmodernism and poststructuralism are often blended, they come from different intellectual traditions. Grenz (1991) says, "postmodern philosophers applied the literary theories of the deconstructionists to the world as a whole" (p. 6).

In the world of therapy, some authors find that *postmodern* is too broad a term because it is used to refer to the arts, philosophy, and popular culture. Michel White (2004) prefers to describe narrative therapy as poststructuralist. *Poststructuralism*, as it relates to psychotherapy, also has to do with questioning structuralist ideas, like the notion that people's difficulties are the "surface manifestations" of invisible, deep-seated structures. Russell and Carey (2004) explain that structuralist concepts in psychology "led many of us to believe that if we wanted to know 'the truth' about a person, we had to

peel away the 'layers' of the self. Structuralism implied that 'deep down' somewhere we could find the 'inner self' and therefore 'the truth' of the person's identity"(p. 94). Postmodern and poststructuralist therapists do not search for deep structures or a true self, but they are interested in people's stories as they choose to tell them.

# *Text Analogy and Narrative Metaphor*

Another aspect of postmodern thought that is relevant to therapy is the emergence of the text analogy and the narrative metaphor as useful similes for human lives. White and Epston (1989, pp. 15–16), influenced by the work of Ervin Goffman and Clifford Geertz, state that we all use *maps* or analogies to make sense of our world. These are our *interpretive frameworks,* or the analogies we chose determine how we understand events and the actions we take. If therapists work with analogies drawn from the physical sciences, they may think of people and their relationships as complex mechanical and hydraulic machines; their problems may be understood in terms of breakdown or damage, and the solutions as repairs or corrections. If we draw analogies from biology, we may see people and social organizations as "quasi-organisms," understand their problems as symptoms, and see solutions as cures.

White and Epston (1989) prefer use of a *text analogy* to guide their work as therapists. From this perspective, problems can be construed as certain kinds of stories and their solution can be found in the authoring of different, alternative stories.

The *narrative metaphor* emphasizes the importance of stories or narratives in people's lives (Anderson, 1997; Bruner, 1990 ; Gergen, 1994; Polkinghorne, 1988; White & Epston, 1989). Narrative psychology proposes that human beings organize life experience as stories of events that have temporal sequences, developments, and outcomes all fraught with meaning (Morgan, 2000).

Life narratives not only describe or reflect our lives, but they constitute them. According to Bruner (1987 ), we become the narratives that we construct to tell our lives. For Anderson, narrative is more than a metaphor about storytelling: "it is a reflexive, two way discursive processes. It constructs our experiences and in turn it is used to understand our experiences. Language is the vehicle of this process: we use it to construct, to organize and to attribute meaning to our stories" (1997, p. 213).

Contemporary thinkers like K. Gergen (1994) and R. Rorty (1979) propose that throughout our lives we are constantly revising our stories and that we modify the meaning of events and relationships. Our personal narratives are fluid and they take place in the context of our interpersonal relationships and our linguistic exchanges with other people.

The self, according to Anderson "is an on-going autobiography; or, to be more exact, it is a self-other multifaceted biography that we constantly pen and edit" (1997, p. 216).

# History of Postmodernism and Psychotherapy

The postmodern critique has had a great impact in social sciences, psychology, and psychotherapy. Some of its implications include (a) questioning of the therapist as an objective observer of the patient/client, (b) awareness of the cultural or ideological biases in our theories, (c) examination of the metaphors that guide our work, and (d) questioning of the self as permanent and integrated. Anderson (2003b) says that postmodernism invites us to reconsider many of the traditional premises about human nature, problems, and therapeutic relationships.

Once again, it can be helpful to contrast modern and postmodern perspectives, this time regarding therapeutic work. Therapists who work in a modern tradition position themselves as objective observers of clients. Modernist psychotherapies are often inspired by a medical model, and the therapeutic process is understood as analogous to a doctor's treatment of a patient. The therapist is supposed to have an expert knowledge about human nature or about the clients' difficulties (Anderson, 1997). This privileged knowledge frequently translates into a marked hierarchical difference between client and therapist, given that the therapist "knows more" than the patient, knows what is "really" happening to the client, and probably has some ideas about how people and relationships "should be" to be functional or healthy (Anderson, 1997). The starting point of modern therapies is generally a psychological diagnosis that determines the goals of treatment and the probable path that therapy will follow. The therapist may know what steps or stages will be taken in the process and designs interventions or strategies to achieve the goals of therapy. The therapist is often the one who determines when therapy should end.

In contrast, when therapists' work is informed by postmodern ideas, it is likely that they see clients as experts in their own lives and see themselves as experts in certain kinds of conversational processes. Therapy starts with the definition that the client has of their dilemma, problem, or situation. The clients define the goals of treatment and can decide when it should end. Therapists try to reduce the hierarchical distance between them and their clients and make an effort to be aware of their biases and to be transparent or public about these. The therapeutic process is not seen as a cure or treatment, but as a conversation in which meanings and alternatives are co-constructed by the client and the counselor as they engage in a process of shared inquiry.

I am aware that I am creating an artificial duality or binary by contrasting modern and postmodern therapies as two clearly distinct categories. This is just for didactic purposes. There are probably no pure modern or postmodern therapies and many therapists may see aspects of both perspectives in their work.

# Common Characteristics of Postmodern Therapies

The remainder of the chapter presents an overview of three postmodern therapies: (1) SFT, (2) narrative therapy, and (3) collaborative therapy. These therapeutic approaches are different, but they share some basic concepts and a philosophical position about relationships with clients. Some of their commonalities include the following 11 categories.

## 1. Transdisciplinary Inspiration

Much of the theoretical grounding of these therapies is inspired by ideas that come from disciplines outside psychology. They are based in the work of philosophers, anthropologists, historians, linguists, and literary theorists. Among them are Gregory Bateson, Peter Berger and Thomas Luckman, Clifford Geertz, Victor Turner, Ludwig Wittgenstein, Hans-Georg Gadamer, Jacques Derrida, Paul Ricoeur, Michel Foucault, Jean-Francois Lyotard, John Shotter, Walter Truett Anderson, and Richard Rorty. In psychology, some of the authors whose ideas have been especially important for postmodern therapies are Kenneth Gergen, L. S. Vigotsky, Jerome Bruner, and William James, among others.

## 2. Social or Interpersonal View of Knowledge and Identity

Collaborative therapy and SFT are identified as social-constructionist (Anderson, 1997; De Jong & Kim Berg, 2002 ). Michael White (2000) says that even though he appreciates many of social constructionist ideas, he'd rather place narrative therapy in the poststructuralist tradition. Narrative therapy, SFT, and collaborative therapy coincide in that our experience of reality or the meaning that we give to our experiences is constructed through our interactions with other people. The same event may be experienced differently in different cultural, relational, or linguistic contexts.

## 3. Attention to Context

Collaborative therapy, narrative therapy, and SFT originally emerged from the world of family therapy, but they have developed through the years. They are currently used to work with families, couples, and individuals of different ages who face all sorts

of difficulties. These approaches can be seen as systemic in the broadest sense of the word: thinking about people in context, be it the context of their culture, their interactions with other persons in their close relationships, or the conversational systems in which they participate.

# 4. Language as a Central Concept in Therapy

The proponents of collaborative therapy, SFT, and narrative therapy share an intense interest in language. Anderson (2006a ) says that language, spoken or unspoken, is the main vehicle through which we give meaning to our world. These approaches conceptualize therapy as a conversational process and believe that dialogue and conversation generate meaning. They propose that the way in which we think and talk about our problems may contribute to further sinking into them or being able to contemplate new possibilities.

# 5. Therapy as a Partnership

Practitioners of collaborative therapy, narrative therapy, and SFT see the therapeutic process as a joint endeavor between clients and therapists. Therapy is not something that is done *to* somebody but something done *with* someone. Anderson (1997) stresses the difference between talking *to* someone and talking *with* someone. Clients and therapist are partners in conversing, building solutions, or developing new stories and identities.

# 6. Valuing Multiplicity of Perspectives or Voices

A recurrent idea in the postmodern critique is that there are many voices or human realities. Truett Anderson (1990) points out that people may have different opinions not just about politics or religious beliefs but also about basic issues such as personal identity. Narrative therapy, collaborative therapy, and SFT consider that a multiplicity of perspectives or descriptions enhances the therapeutic process. Each one of these approaches has developed unique ways of incorporating different points of view or voices into therapy, primarily through the use of questions. Plurality or *polyphony* can also be achieved by incorporating teams of more than one therapist in the session. This is exemplified by work with reflecting teams (Andersen, 1990; Fernández, E., London, S., & Tarragona, 2002), "as if" teams (Anderson, n.d.), "external witnesses," and "definitional ceremonies" (White, 2000). These are formats in which clients get a chance to hear the reactions of other therapists who have witnessed the therapeutic session either behind a one-way mirror or in the same room.

# 7. Valuing Local Knowledge

A very important aspect of postmodern and poststructuralist propositions has to do with the questioning of *universalizing discourses,* explanations that are meant to be applicable to all people. The work of the collaborative, narrative, or solution-focused therapist is not based on *meta-narratives* (e.g., a personality theory), but is rather centered on the client's own ideas and the new ideas that are generated throughout the therapeutic conversations. Inspired by the concept of *local knowledge* discussed by anthropologists (Geertz, 2000), therapists who work from these perspectives are more interested in understanding clients' lives from the clients' point of view than from the perspective of some theoretical presupposition. Therapists want to take advantage of everything clients know about their lives—their problems, stories, possible solutions, and goals. This leads the therapist to adopt a position of curiosity and promotes a relationship of respect and collaboration.

# 8. Client as a Star

Another convergence of collaborative therapy, SFT, and narrative therapy is that clients are the stars of the therapeutic process. The client is seen as the expert in his or her own life, and therapeutic work starts from the definition that the client has about his or her situation. Similarly, it is the client who defines the goal of therapy and when it has been reached. The therapist tries not to assume the role of an expert. Michael White (2000) proposes that in narrative therapy the therapist has a "de-centered but influential" position. Harlene Anderson says that in collaborative therapy, the therapist works from a "not knowing" position (1997, 2005). Peter De Jong and Insoo Kim Berg (2002) have also adopted the term *not knowing* to describe the attitude of solution-focused therapists in their work. Not knowing does not mean that the therapist is ignorant or does not know anything. Anderson (2005) explains that what it means is that the therapist approaches the patient with curiosity and willingness to be informed by the client, trying to leave aside preconceptions and to avoid arriving to conclusions too soon.

# 9. Being Public or Transparent

Narrative therapy, collaborative therapy, and SFT coincide in that therapists are not considered objective observers of clients. All people, including therapists, understand things from a certain perspective—they are standing in a certain place. Therapists must do everything they can to be free of prejudice in their encounters with clients, but because it is impossible not to have personal values, opinions, or preferences, the therapist must be open about these when they are relevant for therapy. In narrative therapy, this is called *transparency* (Freedman & Combs, 1996; White, 2000), whereas in collaborative therapy

it is referred to as *being public* about ideas and sharing internal dialogues with the clients (Anderson, 1997, 2006c).

# 10. Interest in What Works Well

One feature of postmodern therapies that distinguishes them from traditional therapies is the emphasis on what is *working well* in people's lives and on what clients consider important and valuable. Narrative therapists explore the clients' purposes, values, dreams, hopes, and commitments as well as the times they have influence over the problem that troubles them (White, 2004). Therapists practicing SFT emphasize solution building (De Jong & Kim Berg, 2002) and clients resources (O'Hanlon & Wiener-Davis, 2003). In collaborative therapy, Harlene Anderson (2006a) says that her conceptualization of language as fluid and potentially transforming allows her to have a hopeful attitude in therapy "to appreciate that human beings are resilient, that each person has contributions and potentials, and that each person values winds and strive toward healthier successful lives and relationships" (p. 11).

Many postmodern and poststructuralist writers in psychology point out that the language of psychotherapy has historically been a discourse of deficit and that therapy is frequently seen as a technology to fix defective persons. These authors have also expressed their concern for the negative effects that psychopathological diagnoses may have on people (Anderson, 1997; Gergen,Hoffman & Anderson, 1995 ; Gergen, 1990; White & Epston, 1989). The concerns about the excessive emphasis on deficit and pathology in psychology are shared by contemporary researchers and therapists who do not place themselves in a social constructionist or postmodern tradition (e.g., the proponents of positive psychology; Peterson & Seligman, 2004; Seligman, 2002; Seligman & Csikszentmihalyi, 2000). Anderson (2006a) mentions a similarity between the hopefulness of postmodern therapies and positive psychology as more promising than deficit-based psychology.

# 11. Personal Agency

Another idea that has an important place in SFT, narrative therapy, and collaborative therapy is that of *personal agency* (Anderson, 2003 , 2006a ; De Jong & Kim Berg, 2002 ; White, 2004; White & Epston, 1989), which refers to being able to make decisions and take action in your life. White and Epston (White, & Epston, 1989) often use the metaphor of "being in the driver's seat of one's life."

# Duration of Therapy

The length of treatment varies in postmodern therapies. They tend to be brief, especially SFT. Collaborative and narrative therapy can also be short-term, but they're very flexible about this. Generally, the client decides when and if they want to see the therapist again and who it might be useful to include in the next session (a spouse, another family member, a friend). In some cases, narrative and collaborative therapy may be long because clients may see the therapist sporadically over years if this is what they wish.

# Values That Guide Therapists' Work

Harlene Anderson (2003b) believes that collaborative therapy, SFT, and narrative therapy share certain values including:

§ Working from a nonpathological perspective and avoiding blame or classification of individuals or families.
§ Appreciating and respecting the reality and the individuality of each client.
§ Working with the narrative metaphor.
§ Being collaborative in the therapeutic processes.
§ Being public or transparent about biases and information.

Steven Friedman (1996) provides a good summary of postmodern therapies when he says:

*The Postmodern therapist:*

§*Believes in a socially constructed reality.*
§*Emphasizes the reflexive nature of the therapeutic relationship in which client and therapist co-construct meanings through dialogue and conversation.*
§*Is empathic and respectful of the client's predicaments and believes in the capacity of therapeutic conversations to bring forth voices and stories that have previously been suppressed, ignored or dismissed.*
§*Minimizes hierarchical distinctions and prefer a more egalitarian offering of ideas.*
§*Co-constructs the goals and negotiates the direction of therapy, putting clients in the "driver's seat" as experts in their own predicaments and dilemmas.*
§*Looks for and amplifies skills, strengths and resources and avoid being "pathology detectives" and reifying rigid diagnostic categories.*

§*Avoids a vocabulary of deficit and dysfunction and tends to prefer everyday language.*

§*Is oriented toward the future and optimistic about change. ( pp. 450–451)*

Even though postmodern/poststructuralist therapies share values and some theoretical grounding, they can be clearly differentiated in their practices and in *how* these ideas are implemented. Narrative, collaborative, and solution-focused work each has its own flavor; their interviewing styles are different, and they focus on different aspects of the therapeutic process. Each of these approaches is described separately in the following sections.

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# Solution-Focused Therapy

Solution-focused therapy was developed by Steve DeShazer based on the work done by the Mental Research Institute (MRI; Bateson, Watzlawick, Weakland, & Fisch) group in Palo Alto, California, and the ideas of Milton Erickson toward the end of the 1970s. A common denominator between Bateson, the brief therapy team at MRI, and Erickson's contemporary hypnosis is their interest in communication, which DeShazer shared. Insoo Kim Berg (DeShazer's wife) is considered to be the cofounder of SFT. DeShazer and Insoo Kim Berg founded the Brief Family Therapy Center in Milwaukee, Wisconsin, in 1978 and spent over 30 years working with individuals, couples, and families facing a broad range of difficulties (De Jong & Kim Berg, 2002).

One important feature of the development of SFT is that it has been an inductive process of "observing individual interviews and simply paying attention to what was most useful" (De Jong & Kim Berg, 2002, p. 11). Insoo Kim Berg (De Jong and Kim Berg, 2002) comments that when they did this, they tried to set aside any preexisting ideas about the client's problems. This defocusing on problems became a central aspect of their work. The team at the Brief Family Therapy Center realized that too much time was devoted to talking about problems, and there was not enough discussion of was helpful in terms of solutions. They shared:

> *We discovered that problems do not happen all the time; even the most chronic problems have periods or times when the problem does not occur or is less intense. By studying these times when problems is less severe or even absent, we discovered that people do many positive things that they are not fully aware of. By bringing these small successes to their awareness, and helping them to repeat these successful things they do when the problem is not there or less severe, their life becomes better and people become more confident about themselves. (Brief Family Therapy Center, n.d.).*

De Shazer and Kim Berg realized that there is not necessarily a connection between a problem and its solution when, in 1982, they worked with a family that listed 27 different problems. Because there were so many problems and they were not clearly defined, DeShazer and his team could not devise an intervention. They just asked the family to observe "what was happening in your life that you want to continue to have happen." The family returned reporting that things were much better. That began a shift in therapeutic work from "problem solving" to "solution building" (De Jong & Kim Berg, 2002).

Other practitioners and authors who have developed variants of the solution-focused approach include Bill O'Hanlon, who has created possibility therapy (1997, 2003, 2005; O'Hanlon & Bertolino, 1998); Michelle Weiner Davis (1993, 1995, 2003); Eve Lipchik (2002); Scott Miller, Barry Duncan, and Mark Hubble (Duncan & Miller, 2000; Hubble, Duncan, & Miller, 1999; Miller & Kim Berg, 1995); Jane Peller [AU: Add dates.] and John Walter (Walter, J.L. & Peller, J.E.,1992, 2000).

Like all postmodern therapies, SFT understands clients' difficulties as constructed in language. This does not mean that the work is only about language without involving action or behavior. De Shazer (1995) works on the assumption that clients' problems have to do with behaviors that are based on their worldview. However, the SFT model places much more importance on the exploration of solutions than of problems.

# *Theory of Psychotherapy in Solution-Focused Therapy*

## Goals of Solution-Focused Therapy

Establishing the goals of therapy is one of the most important aspects of SFT. It is crucial that these goals be established by the clients. Therapists have a number of ways to help clients clarify their goals. These are discussed in detail in the following sections.

There is one general goal in SFT: to build solutions. There are no preestablished therapeutic objectives defined by the therapist. Each client is different and the therapist tries to empower him or her to build solutions that fit his or her unique experience and situation.

## Assessment in Solution-Focused Therapy

There is no assessment in the traditional sense of finding out what is wrong or arriving at a diagnosis. Psychometric or psychological are not used. There is, however, a

careful inquiry about what clients would like to see different in their lives and about exceptions to problems.

There is no special assessment phase. The investigation about what changes clients want to in their lives begins in the first session and can continue throughout the duration of therapy.

When the therapist is inquiring about exceptions to the problem, the focus is generally on the past and the present. When goals are being established, the focus of the therapist's questions is on the future. Working from a SFT approach may involve talking about the history of the problem or not, but it always includes discussing the future or how the client would like his or her life to be.

Solution-focused interviews can be conducted with individuals, couples, families, or groups. When the therapist is finding out about exceptions and goals, he or she usually asks questions about how other important people in the client's life have noticed or would notice improvement or change.

## Process of Solution-Focused Therapy

From the perspective of SFT, "the mission of the helping professions is to empower clients to live more productive and satisfying lives" (De Jong & Kim Berg, 2002, p. 9). The notion of empowerment adopted by SFT is based on a *strengths perspective.* The practitioner is to discover, together with the clients, the personal strengths and resources that the client may be able to bring to his or her situation. The therapist supports the client's solution building by asking them what they would like to see change in their lives; by listening to the directions in which clients want to go and inquiring about exceptions to problems (DeJong & Kim Berg, 2002).

Kim Berg has adopted the term *not knowing,* coined by Harlene Anderson, to describe the therapist's position in SFT. She proposes that there are some skills for not knowing that include listening, formulating open questions, getting details, echoing clients' words, summarizing, paraphrasing, complimenting, affirming clients' perceptions, normalizing, focusing on the client, noticing hints of possibility, exploring clients' meanings, asking relationship questions, and amplifying solution talk (DeJong & Kim Berg, 2002).

The solution-focused therapist is very actively involved in the conversation, which is a joint exploration of goals, exceptions, and solutions. Believing that clients are experts in their own life does not mean that the therapist takes on a passive role. Kim Berg describes the therapist in SFT as "leading from one step behind," by practicing the skills that allow the client to provide information about his or her situation and him- or herself (DeJong & Kim Berg, 2002).

## Self-Disclosure in Solution-Focused Therapy

Self-disclosure is not common in SFT. Insoo Kim Berg says that they "do not recommend that you tell clients about your own experiences" (De Jong & Kim Berg, 2002, p. 32). The rationale for this is that the best place to look for solutions is in the client's experience and ideas. Kim Berg (2002) adds:

> *Self disclosure is best understood to mean using your senses, critical thinking capacities and thoughts as instruments in the solution building process. It does not mean telling your clients that, for instance, you too broke curfew as a teenager or you too were sexually abused. (p. 33)*

She disagrees with the argument that such sharing enhances rapport and believes that it can impair clients' ability to find their own solutions.Solution-focused therapy is usually brief. De Jong and Kim Berg (2002) report the results of a study of SFT in which 77% of clients improved at the end of therapy with an average of just two sessions. In another study of 275 cases, more than 80% attended less than four sessions and 26% just went to one session. The mean number of sessions was 2.9.

## Therapeutic Relationships in Solution-Focused Therapy

In SFT, the term *therapeutic alliance* is not frequently used, but there is much written about how to develop productive and respectful relationships with clients. Berg and De Jong (2002) describe three different kinds of relationships that can develop between clients and therapists: (1) a *customer-type* relationship in which the client and the therapist together can identify a problem and a solution scenario to work toward; (2) a *complainant-type[AU: Pls. check spelling this is how they spell it]* relationship in which therapist and client can identify a complaint or problem but cannot see a way for the client to build a solution; or (3) a *visitor-type* relationship in which therapist and client cannot identify either a problem or a solution. De Jong and Berg discuss different ways in which therapists can respond to these situations.

## Strategies and Interventions in Solution-Focused Therapy

De Jong and Kim Berg (2002) clearly outline the steps or stages of SFT:

§ Explaining to the clients how the therapist works.
§ Describing the problem (emphasizing solutions and expectations).
§ Finding out and amplifying what the client wants (defining goals).
§ Exploring exceptions (asking the miracle question; using scales).
§ Formulating and offering feedback to the client.
§ Seeing, amplifying, and measuring clients' progress.

## Describing the problem: Emphasizing Solutions and Exceptions

The most important goal of SFT is to build and implement solutions. Solution-focused therapists pay much more attention to exploring solutions than to inquiring about problems. It is important to understand what afflicts the clients in order to better understand what they want to be different in their life or what change they want to achieve, but Kim Berg and De Jong (2002) state that in some cases it is possible to begin therapy speaking directly about solutions, skipping the problem exploration stage. This is not the norm, but it illustrates how, more than solving problems, SFT is about building solutions.

When clients and therapist do speak about the problem and it is clearly defined, they proceed to talking about exceptions to the problem. Exceptions are those occasions in which the problem is not present or is less frequent or less intense (De Jong and Kim Berg, 2002). The client is asked to identify these situations and is asked many questions about everything that is different during these moments: where the client is, with whom, what he or she is doing and thinking when things are better, even if these occasions are few or far between.

## Finding Out What the Client Wants: Defining Goals

To do a good job in SFT, it is fundamental to explore where the clients want to arrive, what they would like to see in their lives instead of the problem that brings them to therapy. Establishing clear goals is one of the most important aspects of this therapy. Having a clear goal is very useful, among other things, because it allows us to measure the progress that the client is making toward it. The goal should be established by the client, and the therapist may help clarify it. It is especially important that the client describes not just what he or she would like to stop happening, but what he or she would like to see *in place* of the problem. An important way to help the clients establish goals is through one of the most well-known tools of SFT: the miracle question.

## Exploring Exceptions: Asking the Miracle Question

This question basically invites clients to imagine what would be different if the problem were solved. Kim Berg and De Jong (2002) emphasize the importance of asking the miracle question correctly, calmly, and with a certain dose of drama. It should not be used lightly or frequently, and it is good to prepare the clients for it by saying, for example, "Do you have a good imagination? Because I'm going to ask you a question that requires a lot of imagination . . ." or "I'm going to ask a strange question, I know it is strange, but there are no good or bad answers just use your imagination . . ."

The miracle question is generally asked in this way, speaking calmly:

*Suppose that while you are sleeping tonight and the entire house is quiet, a miracle happens. The miracle is that the problem which brought you here is solved. However, because you are sleeping, you don't know that the miracle has happened. So, when you wake up tomorrow morning, what will*

*be different that will tell you that a miracle has happened and the problem which brought you here is solved? (DeJong & Kim Berg, 2002, p. 85)*

The therapist can continue asking questions: What is the first thing you would notice? What else would you notice different? The miracle question is extremely useful for several reasons: First, often when we have a problem, we don't see alternatives. Second, because the miracle question is hypothetical and it is not real, it allows a client to give themselves the freedom to imagine a scenario free of the problem, without censoring their ideas. Third, the answer to the miracle question contains the keys or the clues for the solution of the problem and the goals of therapy. For example, a woman comes to therapy because she feels apathetic and lacks energy. We ask the miracle question and invite her to describe what she would notice the next morning that would be an indication that the miracle has occurred. She answers that she would get out of bed fast. This apparently trivial behavior could be a clue to part of the solution to the apathy: not staying in bed and turning off the alarm clock every 10 minutes for 2 hours, but getting up as soon as the alarm clock rang the first time. From there, we could continue talking about what she could do to get up with the first ring of the alarm. Maybe she could experiment with putting the alarm clock away from the bed so she would be forced to get up to turn it off. Or she might ask a friend who is an early bird to call her when she gets up in the morning.

It is important to mention that the answer to the miracle question is just the starting point for conversations. We have to work carefully, asking many more subsequent questions. Among these, questions about the relational system; for example, Who would notice that you got up early? How would you know that this person noticed? Will this person behave differently seeing that you are up?

## Exploring Exceptions: Using Scales

Scales are other characteristic tools of SFT. These are subjective scales with which clients can evaluate, among other things, the intensity of the problem; how hopeful they are about things changing; how confident they feel that they will change; the progress that has been made since the last session; at what point he or she will feel satisfied and much more.

The therapist generally draws a vertical line on a piece of paper and writes the number 1 the bottom and a number 10 at the top. Number 1 may represent the problem at its maximum level and number 10 can be the absence of the problem. The therapist asks the client to indicate where the problem is right now on the scale, to rate how it has been at its worst, and to indicate at what point the client may start to feel that things are better, or at what level the client would need to see the scale to feel that therapy is working.

Scales can be very useful because they establish a baseline and can become a frequent point of reference throughout the sessions. For example, a client comes to therapy because she feels uncomfortable in social situations. In the first session, she establishes that on a scale of 1 (the worst) to 10 (the best) her social comfort is a 3. We

can ask what would need to happen so her level would be up to 4 (to think of a small change). Again, the answer may contain interesting kernels of possible solutions. In the second session, we ask the client how she would rate her current comfort and she says 4. This would probably pique our curiosity about what happened that she went from 3 to 4: Did she do something different? Did circumstances change? What would need to happen in order for it to stay at level 4? Scales can be used in many different situations and they can be adapted to for use with children (Kim Berg & Steiner, 2003).

**Formulating and Offering Feedback**

In every session of SFT, the therapist gives the client some carefully formulated feedback. If there's a team of colleagues observing the session, the therapist may take a break and meet with the team and come back later with a message from the team members. Even if the therapist is working alone, it is common to leave the clients for a few minutes to think and then give them feedback. Feedback in SFT has three components: (1) a *compliment* that recognizes something positive in the client, (2) a *bridge* that has to do with the clients goals, and (3) a *task* or *homework* that generally has to do with observing what is different when things are better or with doing more of what has been working well (De Jong & Kim Berg, 2002).

Sometimes a solution-focused therapist may start a session asking "What has been better since we last met?" This contributes to creating an expectation of change and to establishing the tone of the sessions in which there is great interest in understanding and using what the client is already doing to improve his or her situation and life.

Solution-focused therapy consistently adheres to the steps described above, independent of the presenting problem. De Jong and Kim Berg (2002) argue that it is not necessary to understand a problem to find a solution, and they have research data that "suggest that solution building is consistently successful, regardless of the client's problems" (p. 282).

# View of Medication in Solution-Focused Therapy

In SFT, there is no particular position on medication. If medications are seen as part of the solution by the client, the therapist is interested in finding out how they are helpful.

# Curative Factors in Solution-Focused Therapy

All postmodern therapies have distanced themselves from a medical analogy of therapeutic practices. Therefore, the work is not understood as a cure, but as helping clients access their resources and creativity to build solutions and have their life be closer to what they would like it to be. The focus on building solutions is the main contributor to this process.

## Culture and Gender in Solution-Focused Therapy

Solution-focused therapy, like all postmodern therapies, is not normative. This makes it less likely that therapists will impose gender or cultural biases on their clients. There is not much written about gender and culture in SFT writings.

## Adaptation of Solution-Focused Therapy to Specific Problem Areas

Solution-focused therapy has been successfully used with children, in schools, in protective services agencies, with people with drinking problems and other addictions, with mandated clients, and with people in crisis, among other many others. Recently, the solution-focused approach has been implemented in individual and group coaching. (Brief Family Therapy Center, n.d.) and in business and education.

## _Empirical Support of Solution-Focused Therapy_

Among the postmodern therapies, SFT is the approach that has produced the most empirical outcome research. De Jong and Kim Berg (2002) report the results of a study of 275 clients in which they measured intermediate and final outcomes. Their findings about length of treatment were discussed earlier. The authors conclude that the outcomes of SFT compare favorably with other approaches: intermediate outcome data showed that 74% of SFT clients who were studied improved between their first and their last session. Seventy-seven percent reported improvement in their final outcome, whereas the literature indicates that success rates of other therapies average 66%. De Jong and Kim Berg (2002) note that these comparable or possibly superior results were achieved with fewer sessions than other therapies reported in the literature (median number of SFT sessions was 2, whereas the median number of sessions reported in the psychotherapy research literature is 6). The authors write that there have been other studies of SFT and that even if they do not yet establish its efficacy, there is increasing evidence to support the effectiveness of this approach.

# Narrative Therapy

Narrative therapy was created by Michael White, an Australian social worker, and David Epston, a Canadian born anthropologist living in New Zealand. They met in 1980 and started working together shortly thereafter.

Looking back on the history of his work, Michael White (Denborough, 2001; White, 1995) recalls that in the 1970s he was interested in the philosophy of science. In the early 1980s, he was very interested in the work of Gregory Bateson, especially his ideas on "restraint of redundancy," a set of presuppositions that determine how we respond to the world, which events we single out and give meaning to, and how we transform events into descriptions that later become stories. White (Denborough, 2001; White, 1995) says that later in the 1980s, the ideas of Michel Foucault caught his attention and that was also the time when, with Cheryl White's encouragement and interest in feminism, he started to think more about the narrative metaphor. David Epston (Denborough, 2001) recalls how after a frustrating stint in academics, he worked as an anthropologist with Aboriginal Welfare and emerged from that experience determined to make some contribution to people's life. He went on to study community development and social work. The anthropological perspective and the focus on community have been important elements in the development of narrative therapy. Epston (1989) tells how during the 1980s he "re-imagined" his work, transitioning from a strategic way of working toward a "text/story" approach, under the influence of Kenneth Gergen, Rom Harre, and Michael White.

White's initial therapeutic work was done in a psychiatric hospital and with families who had children dealing with encopresis, fears, and family troubles (White, 1989). Epston also had much experience working with families who had children and teenagers with all sorts of difficulties from illness to perfectionism to drugs to school troubles and night fears (Epston, 1989).

# *Theory of Psychotherapy in Narrative Therapy*

White and Epston (1989) believe that people face difficulties when they live with "dominant stories" that are "problem saturated." These dominant stories are restricting; they do not include important parts of a person's experience and may lead them to negative conclusions about their identity. Freedman and Combs (2002) describe the basic premise of narrative therapy this way:

> *We believe that we all live our lives through stories—the stories we tell and the stories others tell about us. Those stories carry the meaning of our lives; they organize the way we experience our relationships, our identities, and the possibilities our lives hold. We think that people's experience of the meaning of their lives and relationships changes through changes in their life narratives. As their narratives change, what they do and what they perceive change as well. (p. 38)*

White and Epston, influenced by the ideas of Michel Foucault, stress the importance of examining "dominant discourses" and how power is exercised in society. They propose that cultural discourses and power practices have an impact on the stories

that people build about themselves and that it is important to deconstruct them. Morgan defines *deconstruction* in narrative therapy as the "taking apart" or careful revision of the beliefs and practices in a culture that strengthen the problem and the dominant story (Morgan, 2000).

Even though several authors talk about narrative therapy as a postmodern therapy, Michael White locates this approach as poststructuralist. Narrative therapy contrasts with most personality theories and schools of psychotherapy that are grounded in the structuralist tradition. Structuralist descriptions of human experience are based on the notion that there are underlying structures that we cannot see, but whose external or superficial manifestations we can observe. White (2000) adopts a poststructuralist position and proposes that in therapy it is not very useful to think in terms of deep versus superficial. He would rather follow the metaphor suggested by Gilbert Ryle and Clifford Geertz (Morgan, 2000) who talked about "thick descriptions" and "thin descriptions." A *thick* story is full of details, connects with other stories, and, above all, comes from the people for whom this story is relevant. A *thin* story generally comes from outside observers, not from the people who are living it, and it rarely has room for complexity and the contradictions of lived experience. The thicker a description or story is, the more possibilities it opens for the people who are living it.

## Goals of Narrative Therapy

The goals of therapy are defined by the client. Generally speaking, the goals of narrative therapy are to accompany clients in a process of rewriting their lives, so that a painful or problematic story does not determine how they define themselves, whereas the development of other stories brings them closer to their preferred identities.

## Assessment Procedures in Narrative Therapy

Narrative therapy is not a normative approach, so there is no assessment of the client in terms of diagnosis or evaluation. There is, however, a very careful assessment of the effects of problems on the client's lives and the ways in which clients can influence the problems. There is no assessment phase separate from therapy.

White (Denborough, 2001) comments that the narrative metaphor has encouraged him to pay more attention to the temporal dimension of life. Narratives are constituted by events that are linked over time. When therapists inquire about problems and later in the process about *unique outcomes,* they are interested in finding out about the past, present, and future.

# Levels of Self/System

Narrative therapists have a strong interest in community and society at large. One of the goals of narrative therapy is to connect the client's life with the lives of others. Problems are not understood as purely individual matters and part of the conversation is usually devoted to examining the role that communities, families, and society have in maintaining or solving a problem. White and Epston, inspired by Foucault, are interested in understanding the sociocultural system that creates and maintains certain dominant discourses. In narrative therapy, they explore the effect of these discourses and practices on the client's life. For example, when a woman is living with anorexia, a narrative therapist may explore with her the cultural messages about weight and beauty that she has received; they would also be interested in the practices that derived from these discourses, like the self-monitoring involved in weighing herself daily and writing down the calorie count of every thing she eats. The therapist would then ask the client to evaluate the effects of these ideas and practices on her life and to determine if she thinks they have had an effect on her life; and if they have, whether these have they been positive or negative.

# Process of Narrative Therapy

As in all postmodern/poststructuralist therapies, the narrative therapist is very actively engaged in the conversation with clients. The therapist participates mostly by asking questions. Epston sees himself as doing research on problems and investigating the relationships that people have with problems and the knowledge that they develop to address them (Denborough, 2001). Because this investigation is done in conjunction with the clients, David Epston describes himself as a coresearcher. He believes that relationship of coresearchers allows both the client and the therapist to bring together their purposes.

Michael White describes the position of the therapist in narrative therapy as "de-centered but influential." It is *decentered* because it privileges the experiences, concerns, and agendas of the client (White, 2000); it is *influential* because the therapist's questions influence how the conversation goes.

# Self-Disclosure

Narrative therapists are interested in *transparency*—situating their comments, putting them in context, or explaining where they come from (White, 1997).

## Typical Length of Narrative Therapy

There is no standard duration of therapy. Many narrative therapies are brief, but in some cases clients can continue to see the therapist over many years (though usually not at frequent intervals).

## Therapeutic Relationships in Narrative Therapy

The term *alliance* is not used in the narrative therapy literature, but the kinds of relationships that narrative therapists aspire to have with their clients are very important in this approach. Combs and Freedman (2002 [AU: Not in Refs, add there or delete here.]) share some questions that they ask themselves as they try to cultivate "narratively informed relationships" in their work:

§*Am I asking if and how the work is useful and tailoring it in line with the response?*
§*Whose voice is being privileged in this relationship? What is the effect of that on the relationship and the work?*
§*Is anyone showing signs of being closed down, not able to fully enter into the work? If so, what power relation/discourses are contributing to the closing down?*
§*What are we doing to foster collaboration? Among whom? What is the effect of this collaboration?*
§*Is this relationship opening up or closing down the experience of agency? (p. 264)*

## Strategies and Interventions in Narrative Therapy

Narrative therapists do not think in terms of interventions, rather they speak of practices and therapy as seen as a joint exploration. Narrative therapy has a clear working style that includes different practices or kinds of conversations between clients and therapists, including externalizing conversations, identifying *unique outcomes*, and thickening the plot by asking *landscape of action* and *landscape of identity* questions. Other examples, such as working with external witnesses, and the use of therapeutic documents, are detailed in the following sections.

### Externalizing Conversations

One of the features that distinguishes narrative therapy is the way in which problems are talked about. Problems are not seen as symptoms or manifestations of some deficiency on the part of the client. Rather, problems are thought of as something separate or external to the client that is affecting his or her life. If we say that someone is depressive, it is a description of the person. If we say that a person is living with

depression, or struggling with depression, the depression is not defining the person. Freedman and Combs (1996) emphasize that externalization is more important as an attitude then as a technique. They point out, following Epston (1993), that the now common view of problems as symptoms has only existed recently in historical terms and that there are many different ways of thinking about human difficulties.

When therapists and clients talk about problems this way, they have *externalizing conversations*. As people begin to talk about their problems as separate entities, they feel an almost immediate difference. Clients frequently report that externalizing the problem helps them put it in perspective, feel less guilty, and think that they can do something about it.

Externalizing conversations include the following steps: (1) naming the problem, (2) exploring the effects of the problem on the life of the person, and (3) deconstructing, or putting the problem in context (Morgan, 2000).

### Naming the Problem

In narrative therapy, the therapist asks the client to describe and name the problem. It is very important to work with the exact words that the client uses, and we can invite him or her to share images or metaphors that describe the problem. A boy that does not want to go to school describes the problem as "nerves." The therapist may ask questions about what these "nerves" are like: "Are they big, small, smart, slow, kind, funny . . . ?" We can ask the child to draw the "nerves," talking about them as characters in his life.

### Exploring the Effects of the Problem

After obtaining a description of the problem that the client finds accurate and close to his experience, the therapist inquires about the history of the problem. This is not done to find its cause or origin, but to understand it better and to later explore alternative stories. The therapist finds out, for example, that "the nerves" appeared at the beginning of the new school year. The therapist proceeds to interview carefully the boy about the effects of "the nerves" on the different areas of his life: What effect do the nerves have on your relationship with your mother? (They make the mother worry.) What effect do the nerves have on the relationship with your dad? (They make the father get angry and irritable.) Do the nerves have an effect on your relationship with your siblings? (Not really) Do the nerves have an effect on your relationship with your teacher? (They make the teachers think that this kid has a lot of problems and it will be hard to teach him anything in school.)

It is important to "slice thinly" and obtain detailed descriptions of the effects of the problem so that we can later ask about the effects of the person on the life of the problem. We can ask the child "Can you tell me about a time when the nerves almost took over but you were able to stop them?"

*Deconstructing or Putting the Problem in Context*

Narrative therapists also explore the effects that dominant discourses and social practices have on the life of the clients. If you're working with a man has been violent with his wife, one part of the conversation may revolve around social ideas about masculinity, masculine privilege, and the notion that violence is something natural to men or something that they cannot control (Jenkins, 1990). The therapist may ask the client if these ideas have influenced his views on marriage or his relationships with women. The therapist asks the clients to evaluate the effects of these ideas and practices in his life and to take a stance about them.

## Identifying Unique Outcomes

The problem and its effects constitute what White and Epston call the *dominant story*. Once this has been explored in detail, the therapist starts to inquire about times or events in the client's life that contradict this dominant story. There are experiences that could not have been predicted based on the dominant or problem-saturated story. The therapist listens for evidence of other possible stories about the client's identity in the client's account. White and Epston call these contradictions to the problematic story *unique outcomes*. For example, a client says she does not have good self-esteem and that she feels insecure. She has defined her problem as "insecurity," and she wants to explore with the therapist the effects of this on her life. The therapist might ask her to think about moments or events in which insecurity had not affected her so much or perhaps had been completely absent from her life, even for a short moment. The client may remember that when she was in the third grade she organized a volleyball tournament in her school and it had gone very well. Unique outcomes serve as the foundation to start building one or several alternative stories. In our example, knowing that the client was able to behave securely, even if it was many years ago, makes the therapist want to know more about that because that event may be part of a different plot of this woman's life. Once unique outcomes are mentioned, it is very important to explore them carefully, to learn about their history and particularly about the meaning that these events had to clients when they occurred, what they meant for other important people in his or her life, and the meaning that remembering the event has right now.

## Thickening the Plot

Narrative therapy is based on the idea that we give meaning to our experiences by organizing them as stories or narrations. There are certain stories that become dominant in our lives and if they are very limited, they may exclude important aspects of our identity. Finding unique outcomes that contradict the dominant story is the first step toward the construction of alternative stories or plots. Initially it is likely that the dominant story is very strong or has a lot of weight. The person who feels insecure can give us many examples of how, when, and where insecurity has affected her life, but she may just remember one or two occasions when she felt secure and capable. These occasions may be the basis for a new plot or a different version of this woman's life, but

initially it may seem a very fragile story and it is necessary to strengthen this alternative story.

Narrative therapy is described as a process that rewrites the stories that constitute our identity. White (1995, 2004 [AU: Not in Refs, add there or delete here.]) calls therapeutic conversations *re-authoring conversations* that are developed around two types of questions: (1) questions about action or behavior and (2) questions about the meaning of action and behavior. Once a unique outcome has been identified, a therapist can ask many questions about what the client did to behave that way or to take that step or how she prepared herself to act in that manner. These are all *landscape of action*[1] questions (Russell & Carey, 2004; White & Epston, 1989). For example, a teenager who habitually skips school reveals that last week he went to class every day. This is a unique outcome. The therapist asks him what he did to be able to go to school 5 days in a row: What exactly did you do to get to school? How did you prepare to do this? Did anyone comment on your attendance? If you continue going to school this week, what do you think will happen?

It is important to also find out about the meaning of unique outcomes, what White and Epston (1989) call *landscape of identity.* In our example, some of these type of questions could be: What do you think it says about you that after so many absences you decided to go to school? How do you think your teachers are seeing you? Does the decision to go to class have anything to do with something that's important for you? Is going to class connected with your plans for the future?

Morgan (2000) describes four narrative practices that are helpful in strengthening alternative stories: *(1)* re-membering conversations, (2) use of therapeutic documents, (3) accountability, and (4) working with external witnesses. These are discussed in the following sections.

*Re-membering*

White (2004 ) has adopted this term originally coined by anthropologist Barbara Myerhoff. It has to do with membership and with how lives are intertwined. Narrative therapists use the metaphor that we each have our own "club" of life and that we can choose the members of this club—the people that contribute to our seeing ourselves in a certain way and to our being the way we prefer to be. Once unique outcomes have been identified, the therapist can ask questions about other people in the client's life who may know about them, or inquire about anyone else who might be familiar with the client's dreams or values. In re-membering conversations, the therapist may interview the client about a significant person in his or her life. Later the therapist can explore the influence that the client may have had on the life of this other person. For example, if the boy who skips class mentions a teacher who used to be kind to him, we could ask him: What did this teacher do when she was kind to you? Why do you think she treated you that way? What you think this teacher saw in you? How did she make you know this? What hopes or wishes do you think this teacher had for you?

Once these questions have been explored, we could also ask him: What impact do you think you may have had in the life of your teacher? What do you think that the relationship with you meant to her? The main idea in asking these questions is to underline how identities constitute the context of interconnected lives and relationships.

### Use of Therapeutic Documents

White and Epston (1989) used (they still do, I think it should be in present tense) a great variety of documents in therapy. These authors believe that most of the documents that are written about clients (e.g., clinic records, psychological reports) contain negative descriptions based on the language of deficit and pathology. White and Epston think that these documents may contribute to strengthening the dominant, problem-saturated stories that have negative effects on people's identities. They propose that the therapist can offer a counterbalance to these documents by writing *counter-documents* that offer different descriptions of clients.

In narrative therapy, the therapist can write certificates or diplomas as recognition of the client's accomplishments. The therapist can also write letters, verbatim notes of the session, letters of recommendation, letters of prediction, statements of position, and invitations, among many other types of documents (Tarragona, 2003; White & Epston, 1989). Generally, therapists write these documents, although sometimes they do it jointly with clients. Whether they are letters, notes, or certificates, they have a commonality in that they strengthen the alternative stories that emerge in therapy. There are many excellent examples of the use of documents in narrative therapy in White and Epston (1989), Freedman and Combs (1996), and Epston (1989).

### Accountability

Narrative therapy is often described as a political therapy. White and Epston (1989) and other authors like Waldgrave, C., Tamasese, K., Tuhaka, F., & Campbell, W. (2003) are concerned with the risk that the therapist may impose dominant discourses on their clients or reproduce within the therapeutic relationship unfair or oppressive practices. To try to avoid this, they have designed ways of working that promote accountability, an important concept in narrative therapy. Waldgrave and collaborators define accountability as "ways of working that seek to give space to the marginalized, that seek to create the possibility of meaningful, respectful dialogue across power differentials" (Waldgrave et al., 2003 , p. 101). Their "Just Therapy" team in New Zealand has developed ways of addressing gender and culture biases in their agency. They have workers who are members of Maori and Pacific Island cultures, as well as "*Pakeha*" (Caucasian). In the agency, there are sections or caucuses defined by cultural group that meet separately. The Maori and Pacific Islands groups are self-determining and the *Pakeha* group, even though it is also self-run, is accountable to the other two. If members of a group with less power feel there is an injustice, they have the right to call for meetings to have the issue addressed. This is necessary because "although all staff are committed to develop concepts of equality, unintentional impositions are still likely to

occur because of our cultural histories" (Waldgrave, C., Tamasese, K., Tuhaka, F., & Campbell, W. ,2003 p. 99). This group has also worked and written about "culturally appropriate therapy."

### Working with External Witnesses

This aspect of narrative therapy has to do with the importance of "telling and retelling" stories to constitute identity. This work is similar in some ways to reflecting teams (Andersen, 1990; Fernández et al., 2002; Friedman, 1995), but it has developed in a different direction than narrative work. It is also inspired by the work of anthropologist Barbara Myerhoff. White (1997, 2000) proposes that we implement practices that act as *definitional ceremonies* to connect and strengthen client stories. In these definitional ceremonies, the therapist interviews a client in front of a group of *external witnesses* who can be other therapists, family members, or friends of the client, but they are often people who have had some experiences that are similar to what the client is going through.

First, the therapist interviews the client while the external witnesses listen silently. After the interview, the client exchanges places with the team. He or she listens as the therapist interviews the witnesses or they speak among themselves about what it meant for them to listen to or witness this session. When they are done, the therapist interviews the client again, this time about what it was like for him or her to listen to the witnesses. Michael White (2007 )has designed a *map* in which he describes in detail the steps of definitional ceremonies in therapy.

The goal of this type of definitional ceremony is to connect people's lives. Having witnesses when telling a personal story can make it more meaningful. This is especially important when talking about alternative stories that a person tries to expand in the context of other dominant stories that are already well rooted and that have influenced his or her identity in negative ways.

Narrative therapy is used in the same way for a variety of different problems. Some therapists have integrated narrative practices with artistic and dramatic expression in their work with children and adults (Dunne & Rand, 2003; Freeman, Epston, & Lobovitz, 1997).

## View of Medication in Narrative Therapy

Narrative therapy is neither for nor against medication. The staff at the Dulwich Center expands on this:

> *Narrative therapy questions pathologising practices. It is associated with not locating the problem in the person and instead locating the problems in people's lives in their broader social context. This does not mean however that narrative therapy is opposed to the use of anti-psychotic medication in any general way. In some circumstances medication can contribute*

*enormously to people's lives, whereas in other circumstances, it can be used in ways that are primarily for the purposes of social control. In circumstances where medication is involved, narrative therapists are interested in exploring with people a range of questions to assist in clarifying what is and what is not helpful in relation to the medication. (n.d., http://www.dulwichcentre.com.au)*

## Curative Factors in Narrative Therapy

Narrative therapists do not see their work as a cure. Freedman and Combs (2002 offer their explanation of change in narrative practice:

*We think that people's experience of the meaning of their lives and relationships changes through changes in their life narratives. As their narratives change, what they do and what they perceive change as well. We facilitate this process by asking questions to highlight unstoried events, to encourage meaning making around those events, and then to tie the meaning to actions and contexts. (p. 38)*

## Culture and Gender in Narrative Therapy

Narrative therapists have gone to great lengths to examine their possible biases or prejudices (e.g., sexist, hetero-sexist, Eurocentric, racist, classist). There are many narrative practices that are designed to promote accountability to clients and colleagues who may be socially marginalized or live with the oppressing or silencing effects of dominant cultural discourses. There is an impressive body of work that deals with issues of culture and gender in narrative therapy. Just a sample would include Waldgrave, Tamasese, Tuhaka, and Campbell (2003); Jenkins (1990); Denborough (2002); Dulwich Center Publications (2001); Pease, (1997); and Madigan and Law (1998), among many others.

## Adaptation of Narrative Therapy to Specific Problem Areas and Populations

Narrative therapy has been used in work with a wide range of people of all ages who are living with many different difficulties: psychoses, anorexia/bulimia, sexual abuse, violence in the family, troubles in school, problems with attention or learning, chronic illness, loss and grief, imprisonment, migration, bullying, marital conflict, temper tantrums, enuresis and encopresis, fears of monsters, and so on.

## _Empirical Support for Narrative Therapy_

Narrative therapists see their work with clients as a form of research called _coresearch_. The countless published case studies attest to the usefulness of narrative therapy. However, there is very little systematic empirical data on the effectiveness of this approach.

# Collaborative Therapy

Harlene Anderson has chronicled the history and evolution of collaborative therapy (Anderson, 2000, 2001, 2006a). This therapeutic approach originated in the 1970s in Galveston, Texas, with an interdisciplinary team led by Harry Goolishian at the University of Texas Medical Branch. The team worked intensively with adolescents with psychiatric problems, their families, and other professionals involved in their care. This approach was called multiple impact therapy (MIT). The team members were concerned because different family members presented different accounts or realities. They thought that if a group of professionals saw them all, they could integrate the disparate information and have a better picture of the problem. Three therapists and a consultant would meet before seeing the clients to exchange information. Then the team members met with the patient, the parents, and the relevant others while the consultant moved from room to room. The therapists and clients met, in different permutations, over 2 or 3 days. Anderson comments that MIT developed out of clinical experiences and can trace back to this way of working many of the "threads" of what later became collaborative therapy. She says they were at the edge of a "paradigmatic shift," a move from an intrapsychic view of human behavior to a contextual and interpersonal one that focused on the family.

During this time, the members of the Galveston group were very interested in the work of the MRI group in Palo Alto, California, particularly on the importance that the MRI team placed on language and their recommendation that therapists speak the clients' language (see Chapter 10). Anderson tells how the Galveston team originally wanted to understand the clients' language to be able to design better therapeutic strategies, but they realized that they got so involved in what the clients told them that they sometimes forgot to plan an intervention. With time, they noticed that the conversation itself had an impact on the clients. That was the beginning of a way of working that understands therapy as conversational dialogue. With their focus now on language, Anderson, Goolishian, and the rest of the Galveston group began to read hermeneutic theorists and philosophers who challenged strongly held notions of knowledge, language, and reality.

# _Theory of Psychotherapy in Collaborative Therapy_

Harry Goolishian and Harlene Anderson (1988) offered psychotherapists a new way to think about _systems_. They proposed that human systems are "language and meaning generating systems." _Language systems_ are constituted by the people who are having conversations around a certain concern, or _relevance_. The membership in these systems may be fluid or changing because it is not necessarily determined by social roles or family bonds, it depends on who is talking with whom about an issue that's important for both parties. A therapist that works with this conception of systems frequently asks clients if they have talked with other people about their concerns and how the conversations impacted them.

From this perspective, the distinction between individual, couples, and family therapy is not very relevant. Rather, it is important to ask the question formulated by Tom Andersen (1991): "Who should be talking with whom, when, where, and about what?" The therapist often asks clients who they think should be present in the following session. If we're seeing a couple in therapy and they talk a lot about their adolescent children, we could ask them if they would like to invite them to the next meeting. Sometimes you can include a friend, a relative, a teacher, or any person that the client considers important in relationship to his or her situation. The way in which we conceptualize, tell, and discuss a story has an impact on the possibilities for change or solutions that we may see. "There are as many observations, descriptions, understandings and explanations of a problem, including ideas about its cause, location and imagined solution (as well as the therapist's role vis a vis the problem), as there are persons communicating with themselves or others about it" (Anderson, 1997, p. 74). An important aspect of collaborative therapy is to open a space so that all of these perspectives may be expressed.

In a collaborative approach, difficulties are understood as _conversational breakdowns_ or unsuccessful dialogues that lead to a lack of self-agency (Anderson, 1997). The way a situation is talked about, conceptualized, and storied can make a person think that they can or can't do anything about it.

## Goals of Collaborative Therapy

The goals of therapy are established by the client. They are usually clarified and defined through the conversation with the therapist. Goals are not set in stone because ideas and understandings may transform as therapy moves along. The therapist frequently asks the client if they are talking about what they want to talk about and if things are going in the direction they want to go.

On the therapist's part, there are no preestablished goals for a client and no particular content that the therapist believes should be addressed. The therapist does have a goal in terms of process: to foster the development of a dialogical space and to help

create conversations in which all the participants feel they belong. What the therapist can do to achieve this is discussed in the following sections.

## Assessment in Collaborative Therapy

None of these postmodern models has an assessment phase that precedes or is separate from the therapeutic phase; it is part of the therapy process itself. Madsen (1999) has pointed out that assessment is intervention. Even if the interviewer's intent is just to gather information, the conversation that takes place while doing this generates an experience for the client. It may evoke memories, stir up feelings, or clarify ideas. So assessment from a postmodern perspective is understood as an integral part of the therapeutic process.

In collaborative therapy, assessment would take place while the therapist tries to understand the client's initial predicament. The client leads the conversation and can highlight the past, present, or future.

## Process of Collaborative Therapy

Anderson says that in any conversation there are at least three dialogues going on: the external one between the participants and the internal dialogues that each participant has with him- or herself. Collaborative therapists often share their inner dialogue, "make their invisible thoughts visible" (Anderson, 2006c , p. 50) so that they can share their ideas, questions, or suggestions and the client has the opportunity to respond to them. Putting the inner dialogue into words is called *"being public"* and it is a way to keep the therapeutic dialogue going. The process of collaborative therapy is the process of conversation and dialogue, the transformation that language and relationships can generate for the people that engage in them.

## Typical Length of Collaborative Therapy

There is no typical duration of therapy. The client decides, sometimes in each session, when and if he or she would like come back. Some clients only go to a one-time consultation, whereas others may stay for years (though this would be rare).

## Therapeutic Relationships in Collaborative Therapy

The term *alliance* is not commonly used in the language of postmodern therapies, but the relationship between therapist and clients is very important in all of them. Harlene Anderson (2006c ) talks about the client and the therapist as being conversational partners*:*

*The participants become conversational partners who engage in collaborative relationships and in dialogical conversation with each other. The notion of with cannot be over emphasized as it describes human beings encountering and responding with each other as they reciprocally engage in the social activity and community we call therapy. (p. 45)*

# Strategies and Interventions in Collaborative Therapy

Collaborative therapy does not have a series of specific techniques with certain steps to follow. The work of a collaborative therapists does not include designing strategies or intreventions. Rather, as Harlene Anderson (1997, 2003a, 2003b, 2006a, 2006c) emphasizes, collaborative work has to do more with a philosophy or position in relation to the people who consult us. This philosophical stance is manifested in an attitude that it communicates to another that he or she is worth listening to, that we see him or her as a unique person, and that we do not classify him or her as members of a certain group or as a certain kind of person. If a therapist believes this, he or she connects authentically with the other person. Together, they can collaborate and build a relationship. Another important aspect of collaborative therapy is that it is based on the assumption that most people value and want to have a successful relationships and a good life (Anderson, 2003a, 2003b, 2006a)

The collaborative approach is described by Anderson (2003b ) as a group of interconnected concepts (e.g., conversational partnerships, therapy as research, the client as an expert, assuming a "not knowing" position, uncertainty, being public as a therapist, and therapy as part of everyday life) that are detailed in the following sections.

## Conversational Partnerships

The collaborative therapist and his or her client become conversational partners who establish a collaborative relationship and participate in dialogical conversations. To achieve this, it is necessary for the therapist to focus on what the client has to say and to be constantly listening, learning, and trying to understand the client from his or her perspective and in his or her language (Anderson, 2003a, 2003b, 2006c).

## Therapy as Research

The collaborative therapist has a strong interest in *local knowledge*— what the client knows about his or her own experience and situation. Together, therapist and client generate knowledge through a joint investigation in which they explore the familiar and cocreate the new. The client tells his story and by doing this in the context of coresearch clarifies, amplifies, and transforms it (Anderson, 2003b ).

## Client as an Expert

Collaborative therapists consider clients as experts in their own lives. Anderson (2003b, 2006a, 2006c ) says that the client is the therapist's teacher. "The therapist respects, honors, privileges and takes the client's reality (i.e., words, beliefs and story) seriously. This includes what story, or parts of it, clients choose to tell and the way they prefer to tell it—how they choose to express their knowledge" (Anderson, 2006c , p. 46). The therapist is not an expert on the client and his or her problems, resources, or solutions. In a collaborative approach, the therapist's expertise is "in establishing and fostering an environment and condition that naturally invites collaborative relationships and generative conversational processes" (Anderson, 2006c , p. 47).

## Assuming a "Not Knowing" Position

The idea of the client as an expert or teacher is related to one of the most controversial propositions of narrative therapy—the therapist works from a position of *not knowing*. Anderson (2005) explains that this does not mean that the therapist does not know anything, that the therapist is a blank screen, or he or she does not offer opinions. Not knowing, according to Anderson (2005), refers to:

> *the attitude and 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 . . . not-knowing means the therapist is humble about what she or he knows. (p. 501)*

## Uncertainty

Another aspect of not knowing has to do with uncertainty. We can never know a priori where a conversation will lead us or where the session might end. This is because language is generative. When clients and therapist talk together, ideas emerge that probably neither of the parties had before their conversation. Anderson (2006a) says that in the light of a postmodern view of language, we cannot think of causality in human interactions. We cannot predict that if the therapist says or does a certain thing, then the client will say or do another. One implication of this, for Anderson (n.d.), is that the therapist approaches each session as a unique situation and this includes what the client presents and the possible outcome of the therapy.

From a collaborative perspective, the therapist does not provoke a change in the client, but they are both transformed throughout their interaction.[2] Anderson (2006a) prefers the term *transformation* over *change,* because change in psychotherapeutic culture often has the connotation of causality: one person changes or somebody goes from one state to another. Transformation, Anderson says, alludes to the fluid movement in our lives while it preserves a sense of continuity.

**Being Public as a Therapist**

Anderson has described how we all constantly have external conversations (with other people) and internal conversations (with ourselves). To *be public* as a therapist refers to being willing to share our internal conversations instead of maintaining them veiled or hidden. The therapist shares his or her ideas in order to participate fully in the conversation, not to guide it or direct it. Putting the therapist's ideas on the table may also prevent him or her from being from the conversation because what is not said can influence the way in which the therapist asks questions or contributes to the conversation (Anderson, 2006c).

**Therapy as Everyday Life**

Finally, Anderson emphasizes that we are all parts of many conversational systems and that therapy is but one of them. The way collaborative therapists talk in therapy is very similar to the way they talk in everyday life; they use colloquial language not professional or technical language. In the discussion of narrative therapy and SFT, there are examples of the questions that are characteristic of each of these models, like externalizing questions or the miracle question. When we speak about collaborative therapy, it is very hard to give one example of a single question or a type of question because, as Anderson explains (1997, n.d.), these are *conversational questions*. They are very similar to the ones that take place in everyday conversations, whose answers will require new questions and invite us to speak about what is familiar or known in different ways and may open up possibilities. To give an example of collaborative therapy, it would be necessary to present the transcription of a good part of the session, because what is important is the dialogical process and how it can clarify ideas and generate possibilities.

# A Multiplicity of Perspectives

An important idea in postmodern therapies is that there are many perspectives and different possible meanings for any event in life. These therapies value plurality and complexity, and therapists frequently look for ways of including different ideas or voices in their sessions. Collaborative therapists frequently work with reflecting teams in the style of Tom Andersen (Andersen, 1990; Friedman, S., 1995). Harlene Anderson (n.d.) has developed a variant of the reflecting team called the "as if" team. The team members listen to a session "as if" they were different people involved in the situation that the clients are describing. (For example, one team member listens as the client's mother, another as the client's husband, a third one as the client herself. The "cast of characters" is decided by the client at the beginning of the session). At the end of the interview, the members of the team share their reactions speaking in first person, as if they were these people in the client's story.

## Adaptation to Specific Presenting Problems

In collaborative therapy, each client and each session is viewed as unique. Every relationship and every conversation is different. What is a constant across different situations and problems is the therapist's philosophical stance or position regarding the clients.

## View of Medication

There is no special view on medication in collaborative therapy. It can  like any other part of the clients' life, something to be talked about if it is relevant for the people involved in that situation

## Curative Factors of Collaborative Therapy

Anderson (2006a,2003a) states that the two most important factors that promote transformation in therapy are collaborative relationships and dialogic conversations*:*

*Dialogical conversation is distinguished by shared inquiry. Shared inquiry is the mutual process in which participants are in a fluid mode and is characterized by people talking with each other as they seek understanding and generate meanings; it is an in-there-together, two-way, give-and-take, back-and-forth exchange. (Anderson, 2006a , p. 15)*

Dialogue and relationship go hand in hand because certain conversations generate certain relationships and vice versa (Anderson, 2006d ).

## Culture and Gender in Collaborative Therapy

The collaborative approach is conceptualized around the process of conversations, not their content, and does not have a preestablished agenda about what issues have to be talked about in therapy. Culture and gender would be included in the conversation when they are considered relevant by the participants (clients or therapists) in the context of that conversation and that relationship. This does not mean that therapists do not see gender or culture as important issues in life or that they don't have a position about them, but that what they know about these matters does not precede or define the conversation they have with a client. A collaborative therapist tries to avoid seeing people as representatives of *any* category or kind of person and strives to establish a dialogic and collaborative conversation with each person in his or her uniqueness and complexity.

There are many examples in the literature of collaborative work with people in situations where gender and culture can be seen as an important component, including

women who have been battered (Levin, 2006), homeless women (Feinsilver, Murphy, & Anderson, 2006), and eating disorders (Fernández, Cortés, & Tarragona, 2006), among others.

## _Empirical Support for Collaborative Therapy_

Anderson proposes that research about therapy is an integral part of our everyday work as therapists. With every client, she is interested in learning what is helpful or not, and she has interviewed many people in different countries about their therapeutic experiences (Anderson, 1997). She states that most evidence about the effectiveness of collaborative therapy is anecdotal or mentioned in articles that include accounts of clients' experiences. There are also qualitative studies of the experiences of clients and therapists (Gehart-Brooks & Lyle, 1999). An important quantitative study was conducted by Jaakko Sekkula in Finland, showing the positive results of a dialogical approach over a 5-year follow-up with psychiatric patients (Seikkula, J. (2002) ; Seikkula et al., 1995, ). Anderson (2003b) posits that the history of the development of collaborative therapy, in practice settings with challenging clients (e.g., chronic psychiatric patients, children's protective services, mandates clients on probation, and women's shelters) also attests to the effectiveness of the approach.

# Case Illustration: Zest for Life and an Oriental City

_Eduardo came to see me because he felt he had lost his "zest for life." He was a man in his mid-40's who had migrated to Mexico with his wife and young children about 15 years ago. He said that for the past few months he had not slept well, felt apathetic and tired, and had digestive problems. Hearing about the sleeplessness and low energy level, I asked him if he thought he was depressed. He responded "maybe a little," but for him what best described his situation was that he did not feel the_ alegría de vivir _(zest for life) he usually had. I asked him to tell me more about that zest for life and he said that for many years he had enjoyed going to work every day, had many friends, and felt happy most of the time. He had semi-retired a couple of years ago and now did some independent traveling sales. Even though he enjoyed traveling in the Mexican countryside to make his sales, he did it alone most of the time and felt isolated. He thought his work was not challenging for him and he was not satisfied with the amount of money he was making._

*Eduardo also told me that he felt he was facing his parents' mortality, and his own, for the first time. His father had passed away and his mother had recently come to spend a few months with him and his family. Eduardo was shocked to see how much his mother had aged since he had last seen her; she seemed very frail and vulnerable. Seeing her this way "brought home" some of the emotional costs of migration: feeling guilty about not being there for her, wondering if he would be at her side when she died, feeling a unspoken resentment from his sister who lived near their parents and looked after them, and feeling he had missed irreplaceable everyday moments with his extended family. Realizing that his parent was getting old made him think that he was "next in line" and he was aging, too.*

*I asked Eduardo a solution-focused inspired question: "Say you decide to keep meeting with me, we have several sessions, and at some point you feel that the therapy has worked for you. When this therapy ends, how will you be able to tell that it was useful, what would be different?" he immediately said: "I will have recovered my* alegría de vivir*!" "How would that look?" I asked. "It is hard to explain, but it would be easy for me to know when it happened. I would just feel it. I would have enthusiasm to go to work, I would exercise again in the mornings; I would not think about getting old all the time, and I would enjoy the present more, especially with my wife whom I love so much. I would get up in the morning and drive my son to the bus stop. I have not been doing that because I can´t sleep at night, so I don´t get up early enough; it used to be our father-son ritual." I asked him if we had a zest-o-meter that went from 1 (very little or no zest for life) to 10 (a tremendous zest for life), where would he place his zest right now? He said it was currently about 4 and he would feel happy if he could bring it up to 8.*

*After hearing his general description of the situation, I said that I understood there were several things going on: lack of sleep, low energy, digestive problems, not finding much satisfaction in his current work, his parents´ old age, thinking about his own aging, and an examination of what migration meant for him and his family. It seemed that these were all very important to him. I asked him where he thought would be the best place to start the therapy: What was most urgent or in what area did he think it might be easier to get things moving? Without hesitating, he said: "Sleeping! I need to sleep more." I said I thought that might be a good place to start, too, because I had just read a research study that found that sleeplessness cannot only be a sign of depression, but it can actually trigger depression. I wanted to know more about what was keeping him from sleeping. He quickly identified two factors: the most important one was that he lived right next door to a club that was open all night and*

*blasted music full volume until dawn every day. We talked about what he had tried to do about this, from wearing earplugs to sleeping in a different room, to sealing the windows with tape. The music was too loud to muffle. Even his dog was going crazy, he said. He had spoken with the managers of the establishment to try to get them to turn the music down to no avail. The neighbors had written countless letters to the city government, never getting a response. He and his wife had considered moving but could not afford it. He also said they were very attached to this home because he and his wife had practically rebuilt it by hand and they had worked on it for years.*

*The other factor Eduardo identified as an obstacle to sleeping was that he had heartburn every night. I asked whether he had seen a doctor about this. He said he had had this problem for years, but it was now exacerbated. I told him I thought it would be important to have it checked because heartburn can sometimes be a sign of more serious health issues (ulcers or even heart attacks). I also asked if he had considered seeing a psychiatrist who might prescribe a medication to help him sleep and offered to give him the name of one that specializes in sleep disorders. Eduardo told me that he did not like to take medications and that his main health care provider was an alternative care practitioner who used Chinese herbal remedies. He said he would see him first and if he found no relief in a few weeks, he would try the psychiatrist. That was the plan at the end of the first session.*

*By our next meeting, he had already seen his complementary medicine doctor who gave him a remedy that helped his heartburn somewhat. What would really help him sleep happened about 3 weeks later: Unexpectedly, the city government closed the bar next-door. This may seem superficial, but it had a huge impact on his well-being. Eduardo immediately started to sleep better and shortly after that, because he was beginning to feel more rested, he took up exercising in the mornings again. This greatly improved his mood. We talked about studies that show that aerobic exercise several times a week has effects comparable to medication for mild and moderate depression. Eduardo had always liked to exercise and told me how he had designed and built his own home gym equipment made of household items (like cans) and junk yard metal pieces.*

*There is a cartoon by Sidney]Harris in which a scientist is writing a very complex formula on the blackboard. After many mathematical operations and variables he writes, "Then a miracle occurs" and his colleague says, "I think you shpuld be more explicit here in step two." I thought of this with Eduardo because a totally circumstantial factor like the end of the noise at night was almost miraculous for him and triggered a series of positive*

*changes in his life. What happened also reminded me of the research findings that show that the greatest portion of change in therapy is accounted for by extra-therapeutic factors (Hubble et al., 1999).*

*In one of our sessions, Eduardo told me about his work in more detail. He liked the fact that he was his own boss, but other than that he felt isolated and bored. He did not feel he had any challenges in what he did. He said the business was simple and "ran itself." He spoke of his previous job with nostalgia. It was a much more interesting, and he had very good relationships with his coworkers, many of whom had become his friends. He had had an active social life with them. He said he was now realizing that when he stopped working there he had lost more than a job, he had lost his social network, too.*

*Because Eduardo often spoke of his wish to regain his zest for life and how little satisfaction he found in his current work, it made me think of an exercise developed by career counselor Kate Wendleton (1999). It is called the Seven Stories exercise and even though it is usually used for career counseling, I thought it might be interesting to try it in therapy to explore with Eduardo what had previously brought him joy in his life. For the Seven Stories exercise, the person has to write a list of 21 experiences that have brought him or her great satisfaction, regardless of what other people thought. These can be recent or go back all the way to childhood, but they have to be specific instances (e.g., just writing "sports" would be too vague, but "playing defense in the final of the soccer tournament when I was in 11th grade" would be a good entry for the list). The person then has to choose 7 items out of the 21 items of the list, describe them in detail and see what skills and abilities were manifested on those occasions. I asked Eduardo if he would like to try the first part of the exercise. He agreed to compile a list of 21 experiences that had brought him great satisfaction or joy in his life and bring them to our next session.*

*When we met again, Eduardo pulled his list from his pocket as soon as he sat down. I thought we would go through the 21 entries, and then choose and discuss seven stories in more detail. We hardly got beyond the first story. He had so much to say and it was so fascinating to me that we spent almost an hour talking about it.*

*As the first item in his list, Eduardo had written, "building my Oriental city." That sounded intriguing. I asked him what that was and he told me that when he was a little boy, he lived with his family in a small town that had a tile factory where his father worked. They did not have much money to buy toys, but he had fun collecting little pieces of tile that he found on the ground near the factory and building things with them. When he was about*

*9 or 10, he decided he wanted to build an Oriental city, with pagodas, temples, and modern buildings. He had never been to such a place, but had seen some pictures in movies and in a book. Every day after school, he would work on his city. "I would build and build and almost every night my mother would call me for supper and I could not believe the afternoon had already passed, I would lose track of time whenever I was working on my project." He devoted months to his miniature city. It grew and children from the town would come to see it; later his parents let him take over the living room in their home so the city of tiles could fit. Even adults would come by to admire his creation.*

*This story piqued my curiosity, and I asked him many questions: How did you fine the tiles? How did you decide how to use them? Who helped you? What do you think the Oriental city said about you? What skills and qualities do you think it reflected? "Creativity, ability to build things, ingenuity, imagination," he said. When asked how he felt about his work and himself when he built it? He answered that he felt smart because his sister always had better grades than him and he was not a very good student, but this was something unique that he did very well. What did he think the other kids thought about what he did? They thought it was "neat." What about his parent and other adults? His parents must have been pleased[AU: Okay?ok], he thought, or maybe they felt proud because they let him use valuable space in their small house to showcase his project. He thought his father may have felt particularly good about it because he was a very creative man. Some of these questions were "conversational questions" to clarify and understand better what Eduardo was telling me and others were narrative-inspired "landscape of action" questions and "landscape of identity" questions that inquire about behaviors and events as well as the meaning that these have for the person and for important people in his or her life.*

*When I heard Eduardo's account of spending whole afternoons building his city and "losing track of time" until his mother called the family to dinner every night, I could not help but think of the concept of "flow" used by Mihaly Csikszentmihalyi (1997) to describe people's optimal experiences. I shared this thought with Eduardo and asked him if he would be interested in hearing more about flow. He said he was, on a piece of paper I drew a graph in which the horizontal axis represented skill level and the vertical one, the degree of challenge of an activity. Csikszentmihalyi's research has found that flow experiences happen when people can use their skills in activities that are challenging. If the challenge is too low for their skill level, they feel bored; if it is too high for their abilities, people may feel anxious or frustrated. Flow experiences often happen when we are totally*

*concentrated on a task that has clear goals and provides us with immediate feedback. Research shows that having these kinds of experiences often, living what Seligman calls an "involved life" (2002), can significantly contribute to happiness. Eduardo seemed very interested and I happened to have a copy of the book* Finding Flow *in my office, so I offered to loan it to him and he took it home.*

*The following week Eduardo was very animated. He immediately started to talk about Csikszentmihalyi's book and how much he liked it. He said he had finished it almost in one sitting and had already recommended it to a friend. Eduardo said that the book had helped him realized he used to have many flow experiences in the past, doing activities he no longer did. For years, he and his best friend would get very old cars almost for free and fix them up to sell them. It was really fun for Eduardo to figure out how to repair them, to decide how to reupholster them, to paint them, accesorize them, and so on. He said he was rarely having flow experiences in his life nowadays and he wanted to have more. We talked about how he might foster them if he could make boring tasks more challenging or develop new skills. He said he might call his friend again to see if they could go look for an old car to redo. He also wondered if he might be able to fix some of the products he sold and offer repair services to his clients.*

*Eduardo mentioned that he had gone over his list of 21 examples of satisfying experiences and realized that there was a pattern to them: Many of the events that had made him feel very good had to do with building, inventing, and repairing things. As a teenager, he would collect seemingly useless bicycles and make them work again; he practically rebuilt the house where he and his family lived now, and of course, his Oriental city was the most vivid example of his love of building and his imagination.*

*Eduardo seemed sad when he reflected on how he would build many things with his hands as a child, but then had stopped doing this when he was a teenager and went to college. He was silent for a minute and then said that he had not thought about it this way, but he might say he had built something while he was at the university, too: a student group to help underprivileged people. This was the beginning of a conversation about what he defined as a commitment to social justice. We talked about the story of this commitment, and he told me about how he could trace it back to his grandparents, his parents, and the cultural atmosphere of the university he had attended in his country. He said he realized that his desire to work for social justice had been a very important part of his life, but that when he had arrived in Mexico he had abandoned it. There were two reasons for this. First, that he had to start from scratch and build a life*

*for his family. He had no energy to focus on anyone else; there were enough needs to be met right at home. Second, he felt that, as a foreigner, it would not be right to do anything political, and he did not know any people or organizations that worked with community development. Eduardo thought that it might be time to start looking for ways to do some sort of volunteer work.*

*Another issue that came up in our conversations was Eduardo's sense of isolation. He said that he and his car-repair friend had gotten too busy to continue with their hobby and, as a result, they stopped seeing each other regularly. We wondered whether they could start getting together again, either to fix up something or just for coffee. Eduardo said he had not realized how lonely he felt in his current work as a traveling salesman until he spoke about it, and that he would like to have more contact with his friends, most of whom were coworkers from his previous job. He realized that his previous work and his car-repair hobby had "automatically" provided him with a social network and that if he wanted to have one now, he would need to actively pursue it. This was something he had never had to do before. A couple of weeks later, he called a new acquaintance and organized a barbeque with their two families in his home.*

*Eduardo was very happily married. He often referred to his wife in our conversations and I was moved by how lovingly he talked about her. He felt very lucky to have her and proud of how they had faced so many difficulties together and had been able to build a new life for their family in Mexico. I asked him if he would like to invite his wife to join us for some of the sessions. He thought it would be a good idea, but her work schedule and the times of our meetings were hard to coordinate. Still, Eduardo would often comment that he had spoken with Rosa about things we had talked about in our sessions. I asked him about those conversations with her and she seemed very present even though she was not in the room with us.*

*After about 10 sessions, Eduardo said he was feeling much better. He could sleep; he was exercising again; he was inviting his wife to go along on his business travels more often; he was getting together with one of his old friends and was keeping in touch with his sister and mother back home more regularly. He felt that little by little, his zest for life was coming back, that it was reaching 7 on the scale. We decided we could stop our sessions for the time being, leaving the door open if he ever wanted to come back.*

*Building things, sleeping, being a father, being a son, having flow experiences, migration, old cars, friendships, aging, mortality, work, noisy neighbors, nostalgia—these were some of the threads of our conversations. I cannot identify defining moments or specific interventions that brought*

*about change. For me, the work with Eduardo illustrates how conversation and language can be transformational. I believe that our conversations helped him articulate his ideas and feelings and reflect on them. He was able to see things from different angles and to identify what was important for him and what he did well. He imagined different possibilities and started taking steps in the direction he wanted to go.*

*Harlene Anderson (2006c ,p.57)says that the main question in postmodern therapies is "How can professionals invite the kinds of relationships and conversations with their clients that allow all participants to access their creativities and develop possibilities where none seemed to exist before?" I think that Eduardo and I were able to develop such a relationship and have those kinds of conversations. By taking a collaborative stance, I contributed to creating a space for dialogue. Eduardo did his part by openly sharing what he was going through and being very motivated to recover his zest for life. I felt very comfortable with him and was able to share my inner dialogues and bring my ideas to the conversation, trying to convey that he could take them up or not, depending on whether they seemed relevant to him. For example, I knew about Wendleton´s Seven Stories exercise and thought that a list of stories about what had brought him satisfaction and joy might be a good springboard to find out more about his "alegría de vivir." I told him what I was thinking and he agreed to explore this together. The idea emerged from our conversation; I had not planned it before and had never used the exercise with a client. Similarly, I have a long-standing interest in Positive Psychology, but I had not thought of bringing it into the conversation until he started to talk about losing track of time when he was building his tile city. His description of his childhood experiences was what made me think about research on flow and made me want to tell him about it.*

*I think that Eduardo was able to access his creativity by remembering and reconnecting with many experiences in his life in which he had built, designed, and repaired things and times when he had come up with original solutions to problems. He was also creative in the present, thinking about ways to make his travels less boring, imagining possible ways to make his work more challenging, and planning things he could do to rebuild connections with important people in his life.*

*One of the most exciting things about therapy is the uniqueness and unpredictability of each process, the wonder of embarking on a joint exploration with our clients. In postmodern therapies,, you never know where a conversation may lead. Neither Eduardo nor I could have*

*predicted the first time we met that the road to recover his zest for life would go through an Oriental city.*

**[Footnotes]**

[1] The terms *landscape of action* and *landscape of meaning* or *identity* were borrowed by White and Epston from Jerome Bruner.

[2] Even if the most important transformations in therapy are the clients', both Harlene Anderson and Michael White note that our conversations with people who consult with us also transport and transform us as therapists.

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# Annotated References

Anderson, H. (1997). *Conversation, language, and possibilities: A postmodern approach to therapy.* New York: Basic Books. A "classic." The basic text to understand the impact of postmodern though on the field of psychotherapy. It is rich with theory and articulates the philosophical position that characterizes collaborative therapy. The chapters on what clients accounts of what has been helpful and unhelpful for them in therapy, should be required reading for all therapists.

Anderson, H., & Gehart, D. (Eds.). (2006). *Collaborative therapy: Relationships and conversations that make a difference.* New York: Routledge. Anderson offers a clear and succinct theoretical framework on postmodernism, followed by examples of the work of over 30 collaborative practitioners from all over the world.

De Jong, P., & Kim Berg, I. (2002). *Interviewing for solutions* (2nd ed.). Belmont, CA: Brooks Cole. A step by step guide to solution building in therapy. Clear and easy to follow. This book has many

learning exercises and case examples that teach the reader how to actually do Solution Focused work.

Freedman, J., & Combs, G. (1996). *Narrative therapy: Social construction of preferred realities.* New York: Norton. A thorough overview of Narrative Therapy. It presents complex concepts and innovative ideas in a clear, straight-forward way. Full of examples and written in a warm and personal tone. The authors' passion about their work is evident in every page and it is contagious for the reader.

White, M. (2007). *Maps of narrative practice.* New York: Norton. The result of Michael White´s years of work to systematize the "how´s" of narrative practices and to further elaborate their theoretical underpinnings.

White, M. & Epston, D. (1989). *Literate means to therapeutic ends.* Adelaide, Australia: Dulwich Centre. The book that put White and Epston on the map in the therapeutic world. Even though their ideas have evolved over the years, the book still offers a very good introduction to the narrative metaphor in therapy and many case examples, particularly of the use of documents in therapy.

# Key References for Case Studies

Anderson, H., & Gehart, D. (Eds.). (2006). *Collaborative therapy: Relationships and conversations that make a difference.* New York: Routledge. A collection of practice oriented papers that illustrate how collaborative therapy is used in a variety of settings, with different populations and across different cultures.

Epston, D. (1989). *Collected papers.* Adelaide, Australia: Dulwich Centre. A collection of very moving and enjoyable stories about of David Epston´s work with many different clients.

Freedman, J., & Combs, G. (2002). *Narrative therapy with couples . . . and a whole lot more!* Adelaide, Australia: Dulwich Centre. Contains accounts of narrative therapy with couples, individual adults and children that clearly illustrate this approach.

Kim Berg, I., & Steiner, T. (2003). *Children's solution work.* New York: Norton. A book that offers very clear guidelines for doing Solution Focused Therapy with children. Full of touching and fun examples, it demonstrates the usefulness of a solution building perspective with young clients.

White, M. (1989). *Selected papers.* Adelaide, Australia: Dulwich Centre. A sample of Michael White´s early work, with many accounts of his work with clients of all ages who face many different kinds of difficulties, from encopresis, to fears, bickering and isolated lifestyles.

# Web and Training Resources

## *Web Sites*

**Postmodern and Collaborative Therapies**

http://ww.harlene.org

Harlene Anderson's web site with many articles on postmodern and collaborative therapy.

http://www.talkhgi.com

Web site of the Houston Galveston Institute, where the collaborative approach was developed and one of the most important training centers for Collaborative Therapy in the world.

http://www.california.com/~rathbone/pmth.htm

Web site on postmodern therapies hosted by Dr. Lois Shawver. Contains many interesting discussions about postmodern thought and therapy in the archives of the postings of the Postmodern Therapies Listserve.

http://www.grupocamposeliseos.com

Web site on postmodern therapies in Spanish. Home of Grupo Campos Elíseos, a training center for postmodern therapies in Mexico City.

**Narrative Therapy**

http://www.dulwichcentre.com.au

Home of the Dulwich Centre in Adelaide, South Australia, where Michael White works. Many articles and resources on Narrative Therapy as well as an international directory of narrative therapists.

http://www.eftc.org

The Evanston Family Therapy Center. Jill Freedman and Gene Comb founded this institute, which is one of the main training centers for Narrative Therapy in North America.

http://www.planet-therapy.com

A narratively informed web site with resources for the general public and on line training programs for therapists.

http://www.narrativeapproaches.com

David Epston's web site. Articles, resources and information about training opportunities in Narrative Therapy.

**Solution-Focused Therapy**

http://www.brief-therapy.org

Home of the Brief Family Therapy Center in Milwaukee, WI, founded by Steve de Shazer and Insoo Kim Berg, creators of SFT. Many articles and workshop materials and interviews, plus books, audiotapes and videos for sale.

http://www.brieftherapy.org.uk

Web site of the largest training organization for solution centered approaches in Europe.