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FROM THE “WHAT” TO THE “HOW” OF THERAPEUTIC PRACTICE

In this chapter, we will cover:

- Different approaches to understanding the variety of therapeutic theories and models
 - The idea that therapeutic theories are discursive options
 - The implications of this idea for our thinking about therapy, problem, and change
 - The implications of this form of understanding for practice
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The place of theory in the world of therapy is as privileged as it is controversial. It is a privileged place because every therapist recognizes that good practices are necessarily connected to well-established theoretical frames. The assumption is that there is no way of practicing ethical and efficient therapy without a solid theoretical background. This is also a controversial issue because what counts as “good” theory and related practices have been the subject of heated debates since the beginning of therapy as a social activity. These debates center around two questions: how can we make sense of the wide variety of theories of therapy and how can we decide what to do in the face of this variety?

In this chapter we describe different approaches that attempt to answer the question of what to do in the face of a multiplicity of theories of therapy and their implications for practice. We then present our own perspective, which conceptualizes *theories as discursive options*. We also reflect on the implications of considering

theories as discursive options in terms of how we understand problems and change in therapeutic contexts.

A THOUSAND MODELS OF THERAPY

Different therapeutic models, over the course of time, have generated varying forms of therapeutic practice. According to Strong (2021), a psychotherapy model is a standardized and manualized psychotherapy that identifies how therapy should be practiced based on the following premises: “(1) a theoretical explanation of mental health, (2) defined and teachable procedures for assessing and intervening in mental health concerns that are consistent with the model’s theoretical explanation, and (3) interventions, consistent with the theoretical explanation, which have evidential support, and can be tested empirically” (para 2).

Sprenkle, Davis, and Lebow (2013) claim there are at least 400 documented models of therapy. More recently, Strong (2021) asserts that a search on Wikipedia yields over *a thousand* different models of therapy. These models may be different in terms of their explanations about the nature of problems, therapeutic change, and people; they may not even agree on what therapy actually is. However, they are usually sustained on the bases of the following premises: (1) that language represents the world and (2) that a good therapeutic model should be based on a theory that *better represents* the different phenomena that surrounds therapy as an activity.

Let us take a moment to analyze both premises, starting with the second. The vague elaboration of the sentence (the use of the words “different phenomena that surrounds therapy”) is intentional. Among the many different therapeutic models, there is no consensus on *what counts as* such “phenomena” (i.e., what are the concepts that should definitely – no arguments needed – be “on the table” when we talk about therapy).

There may not be consensus on what *therapy* and associated concepts, like problem and change, mean across models. However, the most common use of these concepts emerges within a particular view of *language as representation*. In other words, when therapists describe therapy, problem, and change, they traditionally understand their theories *as if they reflected the reality of the matter*. This is our taken-for-granted notion of language used in our everyday life. Here, language is understood as a set of signs and symbols that either represents objects in the external world, or mental states of our inner lives. From this perspective, words are only as good as their match to a correspondent entity in the world. Traditional scientific practices are based on this view of language. In the physical sciences, systematic observations are presumed to be necessary for the establishment of general laws describing the workings of the world and, this very same principle has been applied to the study of the social world, including therapy (Gergen, 1973). Although this kind of knowledge making has created wonders in different scientific fields – particularly the physical and natural sciences – great debate and criticism has been directed at the implication that such a form of knowing could (or should) be

simply transferred to the study of the social world (Gergen, 1973; Bruner, 1990; Rose, 1996). We will return to this point later in this chapter.

For now, let us return to where we stand in terms of a *traditional* understanding of therapeutic models: language represents reality. Therapeutic models are based on theories that supposedly represent the phenomena surrounding therapy. Theories have divergent understandings of what phenomena count as, as well as divergent understandings of the definitions of various concepts. From within this perspective, there are two ways of addressing the issue of models in therapy and making sense of this variety: divisive arguments and the common factors paradigm.

Divisive Arguments

When confronted with diverse models of therapy, the impulse is often to discern which theory is the valid one, which is the "right" way to conduct therapy. This debate is as old as therapy itself and it arises from the taken-for-granted notion of language as representational. Because traditional theories of therapy talk about their associated concepts and practices as *Truths*, we must decide on which better represents reality. But, on what basis can we make that decision? Consider, for example, the work of a psychoanalyst who is informed by the concept of the unconsciousness. From the development of her therapeutic theory, she believes the unconscious exists; whether or not we are aware of it, it lies somewhere under the cover of our defense mechanisms, and it guides our inner lives. With this belief in hand, therapeutic interpretation is seen as the process through which therapeutic change is brought about, as it brings the elusive unconscious to the realm of consciousness. For her, this is real. This is what she *witnesses* every day in her practice, and her psychoanalytic colleagues can all vouch for this reality.

But then, the cognitive therapist joins the conversation. He says his friends from the neurosciences department have thoroughly researched the biochemistry of the brain and can now confirm that there is no such thing as the Freudian unconscious. There are simply ideas, issues, and thoughts that a person is not conscious of in a particular moment. Therapy, the cognitivist will argue, is about dysfunctional *beliefs* that lead to dysfunctional emotions and behaviors. Through a series of techniques, the therapeutic relationship will help the individual change his beliefs into new, more functional ones. This is real, and not only does the cognitive therapist see this pattern of dysfunctional beliefs leading to dysfunctional behaviors every day in his practice, but his fellow researchers can also all vouch for this reality.

How can we make sense of these differences? Some may argue that they should be resolved scientifically: each therapeutic model must be researched in order to create an evidence base upon which assertions and treatments can be sustained. Good therapy is evidence-based therapy because evidence grants a given therapeutic approach the status of scientific certainty (Depreeuw, Eldar, Conroy, & Hofmann, 2017). However, there has been much debate in the field about the shortcomings of sustaining this evidence-based approach to therapy.

Critiques of the imposition of evidence-based criteria have taken three forms. First, there is the question of what counts as evidence and to whom (Larner, 2004). Though most practitioners agree that therapy should be grounded in evidence, critics point to the flaws of the traditional scientific criteria for determining a practice as evidence-based: the research designs required are too distant from clinical practice of the real world; the evidence-based model has not been tested itself; and it relies heavily on the medical model (Crane & Hafen, 2002). Second, there is the issue of differing ideological biases within research. On this matter, Mantzoukas (2007) argues that there are multiple ways of defining and acknowledging evidence-based practices, and practitioners can only choose among them departing from previous ideologies by which they already abide. These ideologies are formed as people participate in social life, and thus there is no way of stepping outside of these ideologies when analyzing what counts as good evidence. Finally, the evidence-based criterion is challenged on epistemological grounds. This critique analyzes the foundations of science and argues that the social construction of reality cannot be separated from accounts of the world and should therefore become visible in any discussions about reality and truth (Gergen, 1973, 1985).

These very important critiques are not intended to diminish the importance of evidence, but to put the status of evidence – as the one final criterion to good practice – into question. What happens to the world of therapy when we keep trying to decide which model is the best model? In the best-case scenario, we tolerate diversity, but we do not speak across our differences. In other words, psychoanalysts acknowledge cognitive behavioral therapy and vice versa but they do not attempt to allay their differences. However – and any student who has entered the field of therapy has experienced this – the worst-case scenario is much more common. Here, the attempt is to determine the “best” (correct) orientation to therapy. Such a move invites divisive arguments and attempts to discredit alternatives. As McNamee (2004a) has described it, the use of the model takes priority regardless of the therapeutic relationship because the model is based on a theory that represents reality (but whose reality?). In addition, there is a sense of isolation between and among different forms of practice as well as a sense of constant evaluation and distrust among professionals. Professional conversations become stuck, and clients are often caught in the middle of our professional battles for the truth.

Common Factors

The common factors paradigm offers an alternative intended to move beyond the dispute among therapeutic models. According to the authors associated with this movement, there are underlying factors that should be present across different models, and it is these factors that make therapy successful. There are two ways of defining common factors. The “narrow” definition views the common factors as aspects of interventions that may be found across models under different labels or names. The “broad” definition includes other dimensions of treatment, such as therapist, client, and relationship characteristics, for example. The most important point, however, is that common factors are

contrasted with specific factors that therapeutic models use to explain their processes of change (Sprenkle, Davis, & Lebow, 2013).

Here, a model's specific explanation for how it works loses priority, and instead a model is conceptualized as a different "delivery" modality based upon the same common factors. In other words, regardless of what models conceptualize as therapy, problem, and change (the key concepts), the mechanism through which therapy works is always the same. The assumption is that the particularities of each orientation should not be disregarded, but the focus should be on efforts to further develop how the common factors are met (Fife, Whiting, Bradford, & Davis, 2014).

In our opinion, this is an infinitely better option than the first one, where the attempt is to determine which orientation is best (or right). The common factors approach, in contrast to the struggle to determine the "correct" model, does not seek to eliminate diversity. In fact, Sprenkle, Davis, and Lebow (2013) argue for a moderate view of common factors, which does not suggest models are not important; rather, models should be valued, though their most important role is to deliver common factors. This appreciation for diversity is much welcomed. However, we do not think it is enough to answer how we should make sense of the multitude of therapy models. We should note that the premises of the "common factors" are also rooted in the research tradition that understands language as representing the world and which seeks to establish *what is the truth among different models*.

In imposing the common factors on all therapeutic modalities, the original conceptualization that grounds each model is overlooked. Consider the hypothetical example of a moment in a therapeutic session. The client looks at her therapist, tears in her eyes, and says, "thank you for everything you do for me." Imagine that the therapist is a psychoanalyst who is now reporting this moment to his supervisor. From within their psychoanalytical perspective, therapist and supervisor understand that this moment is evidence that the client-therapist "transference" (Freud, 1912) (i.e., the client's unconscious redirection of her feelings to the therapist) is in place. The concept of transference is central to how psychoanalysis understands the workings of therapy, and so the fact that this therapist and supervisor see it happening in the session offers them many potential insights on how treatment should proceed.

Now, imagine analyzing the same therapeutic relationship from within the perspective of the common factors. It could be argued that the client's affirmation to her therapist is evidence that there is a *bond* happening in the therapeutic relationship. *Bond* is one of the original common factors described, and it refers to the nature of affection in the therapeutic relationship (Bordin, 1979). In the present case, seeing the therapeutic interaction through the lenses of "transference" or "bond" invites us into different understandings of therapy. On what bases could one state that *what is really happening* is to be called "a bond" and not "transference?" We believe there are no objective bases to make either claim. Different theories pose different questions, concepts, and foci of interest. Therefore, a multiplicity of descriptions will always be at the center of therapy, and we should be careful not to flatten that multiplicity into singularity, encouraging

one privileged language. Different descriptions provided by theories invite us into different constructions of reality. This is the basis for an understanding of therapy as social construction.

A DIFFERENT VIEW OF LANGUAGE AND THEORY

Given the problems raised above (namely, that there is no objective set of criteria by which to judge competing orientations to therapy and that using the common factors approach leaves us with no clear way of claiming that common factors propose *the one and best language* to describe therapy), we turn to therapy as a process of social construction. Therapy as social construction focuses on an epistemological understanding of models and practices. This is based on an understanding of *language as action*, which is different from the more traditional understanding of language as representation. From this social constructionist standpoint, language does not merely represent the world; rather, it is constitutive of the multiple worlds we inhabit (Gergen, 1973, 1985; McNamee, 2004b).

When Gergen (1985) first articulated the social constructionist movement in modern psychology, he made a case that “what we take to be the experience of the world does not dictate the terms by which the world is understood” (p. 266). His point was that different descriptions of the world arise not from neutral observation, but from social processes of coordination. Through these processes, language conventions are created, and later taken for granted as representations of the world. There is nothing about “personality,” for example, that demands we call it personality. Distinguishing personality from character traits is the byproduct of negotiated language. As we name, we join a tradition of language use which has emerged in social interaction.

However, Gergen explains there is no objective, final criterion to determine whether one language is better suited for the world than another. The very possibility of observing the world is guided by the linguistic categories available to us. Words, concepts, theories, or any other language device that help us understand the world are “social artifacts” (i.e., products of social interaction that is situated in particular cultural and historical traditions). The potential of these words to function in the world is directly related to how well they are coordinated and sustained by communities of people as they make sense of the world.

Finally, since describing the world cannot be accomplished from a neutral “God’s-eye-view from nowhere,” social construction is interested in understanding how different descriptions are coordinated into being, what their effects for the lives of the people who coordinate around these concepts are, and how we could resort to different descriptions and explanations that may create different, more useful realities at a certain moment, if that should be the case.

Here, Goodman’s (1975) phrasing of the issue is enlightening: “If I ask about the world, you can offer to tell me how it is under one or more frames of reference; but if I insist that you tell me how it is apart from all frames, what can you say?” (p. 58).

It's a rhetorical question, pointing out that we cannot ever know the world apart from the frames we have constructed. As Wittgenstein (1953) has argued, words only gain their meaning in their use within language conventions. Following the same argument, Andersen (1996) argues that "language is not innocent," because descriptions of the world have implications for what we take the world to be. When we describe the world, we create it in particular ways and this has implications for how we live our lives. According to Bruner (1990), rather than asking whether a particular theory gets it right, we need more "pragmatic, perspectival" questions, such as "What would it be like to believe that?" Or "What would I be committing myself to if I believed that?" (p. 26). From this view of language, we come to the point of seeing therapeutic theories as discursive options.

Therapeutic Theories as Discursive Options

When we understand therapy as social construction, we do not look at therapeutic theories and models as representations of reality. Instead, we are interested in understanding how models of therapy, themselves, are constructed. What are the historical roots – when, in what context, under what circumstances did each orientation emerge? What are the social questions each model is attempting to address? And, most important, what scholarly debates and ordinary conversations among practitioners have given birth to these orientations? Here we must emphasize, no therapeutic theory has ever been discovered. All theories of therapy are the byproduct of social engagement; they are created within communities, at particular times. Each theory and practice emerges from the coordinated actions within a given community. Therefore, each form of therapeutic practice constitutes a specific reality, with its own understandings about "what is the case," and "how we should relate/practice" with what the case is. These understandings and practices – what Wittgenstein (1953) calls "forms of life" – are internally coherent, but not necessarily coherent across models. Put this way, we are positioned to ask: *Which of the various orientations to therapy might be useful in this moment, for this person/couple/family?*

Therapy, seen as a process of socially constructing an understanding of one's world, liberates practitioners from wrestling with the age-old dilemma of identifying the "right" theory or form of practice. Therapy as social construction invites us to go beyond the dispute among models of therapy to discern the "best" one. Therapy as social construction also invites us to abandon the attempt to find underlying common factors within each theory/model. Instead, we are invited to become curious as to how the very notions of therapy and associated practices are differently constructed from within various communities, and what kinds of "therapy social worlds" – filled with concepts, understandings, particular ways of communicating and being, techniques, resources, etc. – are created.

Different realities are created when we speak and practice in the terms of a particular theory. From this perspective, we may be "promiscuous" (i.e., willing to mix things up, in our inquiries and practices) because we are open to contemplating the utility of each

model as it is coordinated into existence in our practices. Our focus is dislocated from what theories say should happen to how they are actually practiced: *how* different theories and resources are worked out in conversation and what kinds of effects are created as they are used (McNamee, 2004a).

Rather than view theories as competing ideologies, therapy as social construction sees *theories as conversational resources*. Each theory, as a resource for therapeutic conversation, might help us answer the question of how we might coordinate in a way that could introduce a desirable future and move forward with our conversations. Each theory may be *potentially* useful in specific contexts as clients and therapists jointly make meanings about their lives (McNamee, 2004a). Rather than compare, contrast, and dispute various therapeutic models, therapy as social construction focuses our attention on understanding how different models are coordinated into being. Our attention shifts to the language used to describe therapeutic activities within specific communities.

Thus, therapy as social construction does not provide *a new model of practice*. It positions us to understand therapeutic models as discursive options, and so our focus shifts from the *what* of practice to the *how* of practice. Instead of practicing this or that way *because this is the way the world is, and my theory says so*, our interest is in what people *do together* in the activity of therapy – how theories and concepts help professionals and clients generate useful understandings for the latter's life issues – and how that doing effects our ways of relating.

Box 2.1

Let's experiment with these ideas

Gather a group of therapist friends who work from different perspectives. Make some popcorn and, together, watch an episode of your favorite reality television show. You should all choose the same one person and/or relationship to closely observe during that episode. Each person should take descriptive notes of "what is going on" with that person/relationship. Do not share your notes with each other yet. Once the episode ends, each of you should write down a theoretically driven paragraph that explains how your therapist's eye understands the notes you have taken. Try to be clear about the concepts that guide your explanations. When all of you have completed this task, share your different perspectives, and discuss:

- What kinds of realities for that person/relationship are created through the lens of your different theories?
- What kinds of therapeutic actions would become possible when a therapist is guided by each one of these descriptions?
- What kinds of effects do you imagine would be brought about if you took these actions as opposed to others? Are there other potentially useful effects in the theories of your friends?

SENSITIZING CONCEPTS FOR THE PRACTICE OF THERAPY AS SOCIAL CONSTRUCTION

What happens to therapeutic practice when we adopt a stance of therapy as social construction and its related understanding of theories as discursive options? In this section, we will explore the answer to this question. When we are no longer oriented by the *what* of therapeutic practice, but by the *how* of it, the taken-for-granted concepts that orient therapeutic practice are scrutinized. In what follows, we analyze three concepts that play a central role in the grand narratives of the therapy world (i.e., what most models of therapy typically utilize in some way or another, either implicitly or explicitly). These concepts are therapy, problem, and change. We believe these concepts offer a good basis upon which to enter the discussion about how to make sense of therapeutic diversity. Though definitions vary, these concepts are usually present in therapeutic models in one way or another due to the history of the field, the questions the field tries to address, and the practices the field proposes. *Therapy*, as a concept, presents the definition of what the model takes this activity to be. *Problem* is usually the point of entry to therapy in society and defines what is usually central to therapeutic models. *Change* refers to how the model explains the way therapy works.

Being alive and active participants in therapeutic communities, we may also actively engage in the creation of new ways of describing therapeutic practice. Those new vocabularies emerge in response to particular interests, issues, and concerns that arise in the unfolding drama of social life. These emergent aspects of our worlds invite new, previously unexplored understandings and actions in the contexts where they take place. In what follows, we start from this premise to articulate our social constructionist understanding of therapy, problem, and change.

This is a Wittgensteinian understanding of language as practice. Social construction does not define words or actions in terms of representations to either mental states or objects in the world; rather, it understands that meaning is always a byproduct of local negotiations. Words carry traditions of use and somewhat stable meanings because they have been used in particular ways over time. Our job here is to honor the use to which these concepts are put as part of traditions, while not taking them for granted nor naively accepting them as Truth. We must consider the use of words and actions (i.e., language) in their situated contexts (Wittgenstein, 1953).

While therapy as social construction does not offer a *theory* for any of the noted concepts (in the sense of a final truth of what therapy, problem and change *actually* are), we may reconstruct them as *sensitizing concepts*, through the use of relational terms. Sensitizing concepts function to create distinctions of particular aspects of the world that, in being named in a specific way, come to exist in that way for us. As Pearce (2007) says, they invite us to relate to the world in particular terms (i.e., orient our actions in relation to those distinctions). Instead of asking what therapy is, for example, we are positioned to ask "what counts as therapy" for whom, at what moment, and in which particular context? To paraphrase Uruguayan poet Eduardo Galeano (1992), a sensitizing concept "helps us to see."

Box 2.2**The Function of Art/1**

Diego had never seen the sea. His father, Santiago Kovadloff, took him to discover it.
They went south.

The ocean lay beyond high sand dunes, waiting.

When the child and his father finally reached the dunes after much walking, the ocean exploded before their eyes.

And so immense was the sea and its sparkle that the child was struck dumb by the beauty of it.

And when he finally managed to speak, stuttering, he asked his father:

"Help me to see!"

(Galeano, 1992)

In the following pages, we offer our understanding of therapy, problem, and change as sensitizing concepts, as they can "help us to see" therapy as a process of social construction. We also aim to show how these concepts can be helpful in guiding therapists through their conversations with each client they meet.

What Counts as Therapy?

Let us begin by examining the very notion of therapy. This is a taken-for-granted concept; we most often assume we know what therapy is. But what actually counts as therapy? Here, answers vary widely. Our aim is not to detail definitions of therapy, but simply to consider, for a moment, how a psychoanalyst, a behaviorist, a cognitive behaviorist, a Reichian body psychotherapist, or a systemic family therapist would answer the question of what therapy is. Do all the varying "schools" of therapy share a common conception? Do these various modes of therapy share a goal or converge on the desired outcome of therapy? No, they do not. Criteria to determine what is therapy are created within communities of practice. Different communities do not necessarily agree with one another. We might even ask, as others do (e.g., Anderson, 2012b), if "therapy" is the appropriate term for what transpires during client-therapist consultations. All these issues and more leave us ill-equipped to navigate the world of therapy; if there is no consensus on what therapy is, what can we do?

Instead of trying to define *what therapy really is*, a constructionist approach to the subject invites us to consider *what counts as therapy, and for whom*. The central issue is how we, together, create understandings for therapy, and in turn, how these understandings allow us to actually engage in the practice of therapy.

From the standpoint of therapy as social construction, therapy can be described as a process of meaning making, where clients and therapists jointly create understandings

about people and their dilemmas, as well as what can be done about those dilemmas. Unfolding relational processes take center stage. The most important questions are not about people and their inner worlds, but about the co-construction of the very activity of therapy. We are concerned with how we can create transformative dialogue when engaged with clients. To expand on this, we draw on questions we can ask about any given interaction, but, in the present case, specifically considering the world of therapy. We borrow these questions from Pearce (2007). We want to know what people make together, how they make it, who they become as they make it, and, most important, the effects that these makings create for them and their surroundings. And, maybe, if these effects are not desirable, how might we coordinate in a way that would introduce a more desirable future?

We could also explore the collaborative construction of desirable futures by examining the very notions that sustain our practices. Rather than take our practice for granted, we could – and should – engage in self-reflexive critique; critique that analyzes how our unquestioned practices emerged in the first place and the utility of those practices in the current moment.

Box 2.3

Let's look at your own definition of therapy...

- Think about the word "therapy" for a moment. Unpack it. What other words come to mind?
- Describe an image of what therapy looks like to you. Who participates in that image? What are the material aspects of where you are? Are you part of this scenario? If so, how are you dressed? What's your body language?
- Write down a definition: Therapy is...
- Where did you learn that definition? What are the authors/teachers/supervisors who echo that definition? What has that definition afforded you? Has that definition ever made you feel limited? In what ways?

What Counts as Therapy for Sandra?

Sandra is a white, working-class woman in her early 60s. She has recently retired from her lifetime job as a public-school teacher. She volunteered to attend a single session of therapy with psychologists Pedro Martins, Ph.D., and Marina Arantes, in response to an invitation they posted on their social networks. Martins and Arantes were creating an online course about therapy, and they wanted to use video excerpts from sessions with real clients to illustrate the theoretical resources they would present in their classes. Through mutual friends, Sandra offered to participate in one session where

she could discuss a topic of her choice with these therapists. The one-hour session was recorded with her permission to later be used as didactic material in the training of other therapists.

Aside from the formal aspects of negotiation (appointment hour and duration, consent forms and the like), both therapists knew nothing about Sandra's story prior to this encounter. A single mom to two adult sons, Sandra came to the session with the hope to discuss her current life challenges. She identified these challenges as interrelated. Sandra described her first challenge as being a recently retired person who had just ended her eight-year relationship with her partner. The second, and related challenge (as she saw it), was her identity as someone who had spent her entire life trying to prove her worth to others, particularly to her family of origin. She explained that she never felt appreciated by her family of origin.

The session took place in the therapists' private office in Brazil. It was organized in the format of a reflecting process (Andersen, 1987), based on the creation of different positions in the therapy room which are organized by the complementary acts of listening and speaking. Sandra and therapist Pedro Martins sat in the "therapeutic system" (they had the task of speaking to each other), while therapist Marina Arantes sat in the back of the room in a reflecting position (she had the task of listening quietly to the conversation of the other two, while paying attention to her own reactions to that conversation). Later in session, Sandra and Marina traded places: Sandra went to a reflecting position, while Marina shared with Pedro her thoughts and reflections about the previous conversation he had with Sandra. Once this conversation was over, Marina and Sandra once again shifted positions, so Sandra could comment on her own reactions to what she heard in Pedro's conversation with Marina. Reflecting processes are organized in a way that the client has access to the process of how therapists talk about them, so that the meanings that organize their stories can be negotiated in different, more useful ways.

Let's pause and ask: is this session *therapy*? As we have seen, definitions of therapy vary depending on the theory that sustains them. Some may argue that it is the duration of the process that should be considered when answering this question (Lowry & Ross, 1997). Others would say that brief therapy (de Shazer, 1985) and even single session therapy (Hoyt & Talmon, 2014) are therapy as well. What about content? Are there some issues that are always present in therapy and can be used to define it? As our previous discussion about therapeutic models has already shown, this is clearly not the case. Location is no longer a viable criterion either because we now have models of therapy that are practiced in diverse places, such as available spaces (e.g., parks) in the community (Grandesso, 2020), or a client's house (Håkansson, 2015). But perhaps determining whether it is therapy is less important than understanding how useful a conversation is. Of course, utility also has to do with socially constructed criteria. Understanding what is useful depends on processes of social coordination – different theories will construct utility in different ways; while people will also, in their local encounters, make use of discourses of utility to understand their local therapeutic realities. Since there are no definitive criteria to define what therapy is, we should always resort to our more situated version of the question: What counts as therapy? In our specific case, we should

ask what counts as therapy for us in the context of this conversation with Sandra. Here, we echo therapists who come from a dialogic perspective of therapy who see it as a context of meaning making (Andersen, 1987; Anderson, 2012b). From this perspective, this conversation with Sandra very much counts as therapy, because the whole dialogical context is built around the notion of a session where Sandra can talk about matters of importance to her, of her own choice, and where therapists participate in a process of meaning making with her, so that new understandings can be created. For a more detailed discussion of the dialogic context, see Chapter 3, p. 42.

What Counts as a Problem?

A problem gains its status as a problem as people participate in social life. What counts as a problem is as much defined by our insertion in forms of life, as it is by our understandings. There are certain "things" (use of the generic here is purposeful) that we can name as a problem: behaviors, interactions, individuals, relationships, social systems, material conditions, etc. These "things" are not defined by any individual alone. However, it is in the context of our more mundane, day-to-day interactions in relating to these "things" that we come to understand what constitutes a problem to us in a particular moment. A problem is therefore a relationally and socially defined phenomenon, characterized by what people define together as a problem. Thus, the emergence of "a problem" is brought about as the lives of those involved are informed by that understanding. There are many ways of understanding a particular situation and calling something a "problem" is a specific way of making meaning.

For certain practitioners, this understanding suggests, in some contexts, that the word "problem" – as a guide for practice – might be altogether banished from the therapeutic vocabulary (e.g., de Shazer, 1985) or at least be left to a secondary place, in favor of other stories which are not organized by the problem (e.g., White, 2007). For others (Anderson, Goolishian, & Winderman, 1986; Andersen, 1987; Katz & Alegria, 2009; Anderson, 2012b), the notion that a problem "exists" because people coordinate their understanding in such a way to construct something as problematic, positions therapists to be attentive to their own participation in the therapeutic conversation and how their questions, bodily reactions, punctuations, expressions, etc., co-construct the reality of the problem (Strong, 2009). Therapists make choices regarding what they should address and how, and these choices create distinctions in clients' stories. These distinctions allow participants in an interaction to see "A," and not "B," as the "object" under scrutiny. Meanings are worked out. Some are strengthened. Others are omitted. Therapists and clients together create openings and closures. As in all interaction, each response opens some possibilities and closes others. To acknowledge this is to understand that meaning is always unfolding.

This attentiveness to the meaning making around what counts as a problem is an important asset, because it lets us explore different understandings *with* our clients, in the moment of interaction. In this way, different theories, employed as discursive options, help us co-construct therapeutic realities that are useful for the client.

What Counts as Sandra's Problem?

Th: So, I thought we could start by asking you, in a general and open way, what do you think is important for me to know about the story that brought you here today?

S [very emotional, already crying]: Relationships. I found out that I am not able to be in relationships with other people. And that hurts a lot. [...] And I... I have found that in all aspects of my life... I feel destroyed. I feel fragile. Financially, physically, spiritually, emotionally. I think I've reached my limit. You know? And I cannot deal with that alone.

Sandra began by telling the therapist a story that was centered around her recently discovered inability to relate to others. The heartfelt way in which she did so, as much as her words, created a sense that she was going through a tough period where she felt "destroyed" and "fragile" in many aspects of her life. In fact, in what followed, Sandra wept as she stated that she had been spending her days crying. She spoke about different moments in her life, from a tough childhood to a failed marriage, from her relationship with her children to her retirement and the recent ending of her significant relationship. She said she did not feel able to sort out her own life. At that point, her story was delineated in terms of her struggles. But what exactly could be constructed as Sandra's problem in the context of that session?

Before we see what happened, join us in a thought experiment. What if we listen to Sandra from the standpoint of an individualist, diagnostic, medical perspective? Our attention would certainly be caught by various signs and symptoms in Sandra's story. She cried a lot, frequently for no reason, by her own admission. She felt unable to solve her problems. She did not feel worthy of relationships. Should we pursue that line of inquiry with no reflection, we would very soon stumble onto a medical label: Depression. Now let us imagine that, as therapists, we hypothesize "depression" as Sandra's diagnosis. What kind of conversation would follow that? It would very likely be one centered around signals and symptoms aimed at the confirmation (or disconfirmation) of such diagnosis. Is this a bad conversation? Not necessarily. Is this a good conversation? Not necessarily either. The point of therapy as social construction is to see this is *a possible* conversation, not necessarily *the one* conversation to have. It is not about good or bad, or even right or wrong; it is about utility. How does engaging in a particular way of describing a problem help therapist and client to move on together? How is a description useful (or not)?

Since we understand that what counts as a problem is worked out in conversation, and that this is as much a responsibility of the therapist as it is the client's, we are positioned to explore our options. Let us note that, in the case of our experiment, the word "depression" came into the conversation from the therapist's own immersion within a medical discourse. Sandra never actually uttered the word depression. Whatever she was going through, she was using a different way of "linguaging" her experiences.

So here is another option, one that comes from the "not-knowing stance" posed by collaborative-dialogic practices (Anderson, 2012b). What if we, as therapists, could suspend any hypothesis we have generated (or maybe even suspend the very idea of hypothesizing) in favor of having other conversations centered on defining – together with Sandra – her "problems?" Consider yet another, complementary, option; an option that comes from solution-focused therapy (de Shazer, 1985) and narrative therapy (Madigan, 2019). What if, instead of feeling obligated to jump into a conversation about problems, we explored Sandra's resources, hopes and dreams? Different conversational realities for Sandra's "problem" could be created as a byproduct of interaction, depending as much on how we, as therapists, decide to respond to her, as on how she decides to respond to us.

So now, let us go back to Sandra's session and note that what the therapist actually did was informed by the latter two discursive options, in the form of the following conversation.

Th: And, when you come to this conversation today, Sandra, what is your hope in coming here?

S: To cure myself. To find a path. To end this pain.

The therapist's invitation to talk about Sandra's hope for the session led to a conversation about curing what she called past traumas that came from a tough childhood. Specifically, Sandra described that she never felt appreciated by her mother and siblings, and she had to fight her whole life to prove herself to them. Through the description of these tough times, a strong version of Sandra, a person who had struggled but succeeded in many aspects of her life, also appeared in conversation. This is where the different aspects of her story – struggle and success, exclusion and acceptance – converged into the following excerpt.

S: I have conquered many things. For example, my job, my house. But I've done all this in order to prove to people that I was not what everybody told me I was. I had to prove to them that I was different.

Th: And so, you proved that?

S: I did. And, today, I feel like – because I had been proving myself to everyone all the time, that I was not that person – I got like this. I spend my days crying.

Th: That gets me feeling... I thought of a word... "tired." Is it like you're tired of proving yourself?

S: I am!

Th: You're tired...

S [cries harder than ever in session]: I *am* tired.

This is an important moment in the session. Sandra was very emotional, as seen in her tone of voice, the way she moved her head in agreement as the therapist spoke, and that she started crying even harder as she said she was tired. Together, those aspects

created a sense that “being tired” was a good description for what she was going through at that point. This word was offered by the therapist. However, it did not come from a previous theory that describes certain scenarios as “a problem of being tired.” The word arose as a byproduct of this specific therapeutic conversation; it arose from what Shotter (2012) calls “*witness thinking*,” working together with clients, as opposed to “*aboutness thinking*,” where the therapist knows best and talks “about” the client’s problem.

Now consider the implications of this process of meaning making around what counts as Sandra’s problem. If, as it could have appeared from a taken-for-granted position, the problem was either her childhood traumas (as Sandra originally stated) or depression (as we considered in our thought experiment), there would be certain implications for how Sandra was positioned and what she could do in relation to her problems. How does one change childhood stories that have lingered for so long? How could she cure depression when she is feeling so hopeless? These are not impossible tasks, of course, and they could be valid ways of constructing a conversation. But if we think about how a great deal of Sandra’s suffering came from her feeling incapable of sorting out her life, maybe such constructions could reinforce her sense of incapacity.

Instead, when she and her therapist together crafted the word “tired” as a name for her current experiences, Sandra gained a new context of meaning for her problem. With this new context, new possibilities for action were created. Maybe curing childhood traumas felt impossible. Maybe curing depression could have been too big of a challenge. But being tired of proving herself at a particular point in her life seemed like a more suitable task. Trying to find a way to move forward from that became central to the whole session from that point on. We had an organizing theme for the conversation from whence change could be worked out.

What Counts as Change?

Like “problem,” from the standpoint of therapy as social construction, “change” is also defined in relational terms. Change is what people who participate in the negotiations in and around the therapeutic context define as change. It is not understood, therefore, in therapists’ pre-defined expert language; rather, what counts as change is worked out from within therapy itself, as a byproduct of negotiation, while speakers make use of different available social discourses that inform them about what can be negotiated as change. Of course, people bring their own understandings of change into therapy based on their previous experiences, which are defined by different social discourses about therapy that emerge within the competing therapeutic theories. Again, we would do well to remember that our conversation in relation to therapy as social construction is never about either/or (which definition of change is the best), but it is about how these different definitions are worked out as helpful (or not) in the moment of therapy. If therapy is defined in terms of processes of co-constructing realities, then when therapist and clients are jointly crafting meanings around people and their problems, they are also engaged in transforming these meanings. They open possibilities, new ways of understanding. New forms of action and coordination can arise from those differences.

Here, the definitions of change from different models are seen as *possibilities* for how we position ourselves in the therapeutic conversation. Just as an illustration, collaborative-dialogic practitioners describe change as intrinsic to dialogue, because it is created as meanings are negotiated and transformed through interaction. Thus, it is the therapist's job to engage in conversation with clients as partners in curious exploration of their stories. Through this relational and conversational process, they aim to open ways forward with their questions and observations in a manner that has not previously been explored by clients themselves (Anderson, 2012b). Narrative therapists, on the other hand, believe that therapeutic change comes from the liberation of clients' stories from the influences of oppressive social discourses. This liberation is accomplished by means of exploring unique outcomes and other narrative constructions (White, 2007; Madigan, 2019).

Therapy as social construction positions us to look to our moves in therapeutic practice as handcrafted, byproducts of interaction. Surely therapists have expert knowledge in many areas, and they can be put into action as relational resources (i.e., as invitations to further conversation, rather than truth statements) (McNamee, 2004b). We believe that the most useful kind of knowledge a therapist can have is dialogic knowledge. Therapists are skilled in the construction of fertile conversational arenas for meaning making. Change is constructed in such conversations and ways of interacting, as we navigate therapy while informed by theories as discursive options.

What Counts as Change for Sandra?

Sandra and her therapist had jointly created an understanding that her life circumstances had come to a point where she felt tired; she was sick of being strong and proving herself all the time, but she did not know how to proceed from there. At this point in the session, she said that sometimes she just felt like "quitting everything." That is a strong expression, and it felt particularly heavy in the context of this session. However, what does it mean? More specifically, what did it mean as it was used by Sandra in the context of that interaction?

Therapy as social construction does not take words for granted. Instead, it proposes that we inquire into the particular use and effects of our words and actions. This is the basis for many powerful therapeutic conversations, as therapists and clients negotiate meanings for the client's experiences. The transformation of these meanings and understandings in therapeutic dialogue is what we call "change." So, instead of being "too quick" to understand the meaning of "quitting everything" (e.g., as a sign of depression), Sandra's therapist takes another road.

Th: When you think about quitting... Think about quitting everything for a moment... [...]

S: To me, quitting everything would mean going to a place where I do not know anyone, and I could show people I am weak in every way... And that I also need to be cared for, to be seen, to be heard.

As it turned out, “quitting” to Sandra, meant she wanted the possibility to show her weaknesses and to be valued (in the form of feeling cared for, seen, and heard). As Sandra explained this, she was also creating a description of a preferred future for herself where things that she valued, but now did not experience, would be present in her life. Following this understanding, the therapist further inquired about these values for her; what did they look like in practice? When, where, with whom, and how has she felt cared for, seen, and heard in her life? It is in this context that Sandra’s relationship with her younger child was brought into the therapeutic conversation as a resource in her life. She said that her younger son was the one person she could talk to when she wanted to feel heard. This opened a conversation about how wonderful her children were. The therapist then asked, “what did you offer them, such that they became these wonderful people?” Sandra could not answer that. The therapist then reframed his question, in the form of a circular one (i.e., he asked her to imagine an answer for the question from the perspective of a different person – her children) (Selvini Palazzoli, Boscolo, Cecchin, Prata, 1980; Tomm, 1988).

Th: What if I asked them [her children] ... what they learned from you that allowed for them to be like this?

S: I don’t know. Maybe... that crazy life I was leading... Working, being a father, being a mother... And, I think the sense of security I have always offered to them. I had to be strong. At some point, I said to them, that anything good I had to give them I had already given. And that I had nothing left. I think I was already close to this period where I’m feeling bad.

Th: It was that security...

S: Yes.

Th: Which had allowed them...

S: To get where they are.

Th: And to have a different life than the one you had.

S: I think I did it.

Th: So, when you saw your job was done... you could break down.

S: Maybe it’s that.

Think about this. In the beginning of the session, Sandra was saying she felt destroyed and she did not know what to do with her life because there were childhood traumas involved, a lifetime of struggles, and a current context of finding out she was unable to relate to other people. As the therapeutic conversation began, meanings were put into motion. Sandra’s problem was defined as “being tired,” and her desire to “quit everything” could be understood in the context of her will to be heard and seen in life. Then, from the therapist’s inquiry into exceptions (de Shazer, 1985), where Sandra already felt she was heard and seen, she described that there was at least one relationship in her life where that already happened – the one with her younger child. And, if we asked him, maybe he would tell us that Sandra provided him and his brother with a sense of security, even though she did not have that as

a child herself. So, when Sandra finally understood that her job was done, she could allow herself to be tired and break down.

This process – the step-by-step negotiation of Sandra's story in the lively context of therapy – is how change was created in dialogue. From within the therapeutic conversation, Sandra not only gained a new definition for her problem, but that definition came with new contexts and, therefore, new possibilities of action that could be pursued throughout the remainder of the session. She could try to reach out more often to her children. She was able to redescribe her relationship with her family of origin (who now recognized that she was a good person). Most important, she and her therapist later would craft an understanding that, because she felt like she had done something in the past without having a model for it, perhaps she could, again, also live into the future without a blueprint.

Box 2.4

Let's practice together

Now that you have learned some things about Sandra in this session, join us in an experiment. Imagine that you are part of this session in the reflecting position, where you listen to Sandra's conversation with her therapist. Your job is to pay attention to your reactions to this conversation, and when the time comes, you will pick a few reflections to share with the other therapist, while Sandra listens. Take note of two or three comments that come to your mind as you think about Sandra's story (perhaps it can be helpful to return to the transcripts in this chapter while you do so). Now, analyze your comments, and figure out:

- Where did the idea for each comment come from? Is there a theory behind it? A hypothesis? Art? Life experience?
- What would you like to accomplish in sharing those reflections out loud? How do you imagine they could be helpful for the therapeutic conversation?
- Remember that Sandra would be listening to your comments. Does that change the way you would phrase them in some way? How?
- Think about other theories/models/inspirations that you know. Can any of them help you come up with another helpful reflection that you would like to share?

IMPLICATIONS FOR PRACTICE

A practitioner who is informed by therapy as social construction is a philosopher as much as a therapist. She is a philosopher because she is not simply interested in *what to do* (i.e., in therapeutic techniques). Instead, her focus is on understanding *how* knowledge is created; how she comes to understand therapy, problems, change... and anything else that might become of interest as she is immersed in the multiple worlds of therapy that are constantly under reconstruction through the interactions of the various people participating in it.

Generative Uncertainty

When we see theories as discursive options, we are invited to use them not because they are superior or right, but because clinical wisdom allows us to understand that particular ways of interacting may aid us in constructing ways of “moving on together” with clients such that we can support and help them with their dilemmas. If there is not a single definition of therapy, problem, or change, therapists are invited to create dialogic contexts where the negotiation of these meanings is favored. Every response in a conversation is seen as an invitation to a further response, where speakers are jointly making meanings about who they are, what their problems are, and how they can act in relation to their problems. This invites a respectful stance toward knowledge and the world of the other, a kind of “withness,” dialogical thinking where the openness to co-construction with no specified results is key (Anderson, 2012b; Shotter, 2012).

This is a position of uncertainty because we cannot ever know what the results of a given interaction are going to be before we have actually lived through it. McNamee (2004a) has proposed “generative uncertainty” as the position that social construction invites us into. Generative uncertainty allows us to question our own assumptions as the only real and valid ones, and navigate a multiplicity of resources as allusive, tentative descriptions that allow for the construction of change.

Where can we find inspiration for such a creative stance? We can find inspiration in every theory, every form of knowledge, every piece of art, or personal experience. Think about the therapeutic conversation with Sandra, for instance. As our analysis has shown, the therapist was not informed by a single model of therapy. Instead, he used various contributions that came from collaborative-dialogic practices (Anderson, 2012b), solution-focused therapy (de Shazer, 1985), and narrative practices (Madigan, 2019), to cite a few, as the conversation unfolded. None of these possibilities was pre-planned. They presented themselves as viable options with particular effects in the course of the conversation.

Attentiveness to the Effects of Our Ways of Interacting

When we understand that together we construct the world of therapy – whether in theory or in practice – we are invited to see our fingerprints in these constructions and to ask ourselves how we can contribute in ways that might improve our work. Therapy as social construction invites us to realize that we are responsible for the world in which we live. It positions us to be attentive to our every move because we know that these moves participate in the coordination of actions that create certain realities and restrain the possibility of other realities. In speaking with each client, we are aware that every conversation opens some possibilities (for clients to understand who they are, what their problems are, and what can be done about them), and that these possibilities carry implications and effects. Who are we committed to as we – as professionals – evaluate these effects? To what kinds of social world are we responding and contributing as we practice? Who gains and who loses as we participate in the world in this specific way?

This focus on the *effects* of our ways of interacting – both to the interaction itself, and to the constructions of the world of which we are a part – is central to the practice of therapy as social construction.

As an example, in Sandra's session, we can use Marina Arantes' comments as part of her reflecting position in that conversation. When invited to speak, she shared some different thoughts about aspects of the therapeutic process that she thought could be useful to Sandra and the therapist. As a final comment, she decided to add something:

M: I wanted to share something – and maybe that's not even that useful to our conversation – but... we can't learn what we value if we haven't had that at some point in your life, right? [...] So, I wanted to know, where did she learn she wanted to feel that way? In which relationships, which moments of her life has she felt like "wow, it is so good to feel safe, to be acknowledged!" I wanted to hear more of this story, because it seems like something important... and that she was able to offer those things to her children, as a mom.

As we can see, Marina was uncertain about the utility of this reflection. It was surprising, then, that out of everything she said, this was exactly the point where Sandra decided to restart her conversation with Pedro.

Th: Out of everything Marina has said, what struck you the most?

S: Security... which she saw a big distance, right... The security I did not have, and the security I was able to offer my children. It was precisely because I didn't have it that I was able to give them that, you see? I had to find it in me [hand gestures as if something was coming out of her chest]. Right? Because I didn't want my children to go through the same as I had to.

Resources and interventions do not work in themselves. Their effects are not a fore-gone conclusion. They are always dependent on a process of supplementation, on the next move that confers them with some meaning, and not others. The difference of therapy as social construction is this: we are more committed to the process itself than to what our theories say. If the effects of a given way of interacting are not desirable, then we can shift, allowing ourselves to be informed by a different way of interacting... and maintain an attentiveness to what happens next. Our focus is on the practice, on the present, and what that creates for the world.

Focus on the Interactive Moment

Finally, therapy as social construction focuses our attention on the interactive moment (i.e., what people *do together* as they speak and act, and what that doing makes). Past and future are understood as narrations in the present; whatever *happened* or *will happen* is being negotiated in conversation, right here, right now. This is our focus. And this focus works to understand therapeutic models as well as clients' stories. As for therapeutic

models, our point should already be clear: we are interested in how the descriptions offered by theory might or might not be generative for a particular conversation, with a particular client, at this particular time. As we do so, clients' stories and the understandings of their stories are negotiated. Meanings are crafted and transformed and so are the possibilities of clients' decisions concerning how to move on with their lives.

Let us consider Sandra's story one last time. Her narration of the "facts" about herself and her family was one that made possible her feeling of incompetence in dealing with relationships in her life. However, as the therapeutic conversation progressed, new meanings for this story started to collaboratively emerge between her and the therapists. The following excerpt illustrates this point.

Th: Not having it [security from your family] has taught you to have it.

S: Yes. Not having security, and having suffered a lot because of that, and not having someone to count on... that's what has changed me so I could offer that to my children, and they could feel they could count on me.

Marina's invitation as to where Sandra had learned to have security had an unforeseen effect: Sandra reaffirmed that she never actually had it in her life. However, at this point in the conversation with the therapist, they create together a new connection in the story that was not previously there. Yes, Sandra did not have security, but this made her into a mother who could provide it for her children. Note how different this construction of the story in the interactive moment is from the one before. In this version, Sandra is someone competent enough in her relationship to her children. She is someone who could provide them with security, even though she never received it. The meanings of a story are always "on the way;" meaning is always unfolding. A narrative is always a work in progress. And so, the possibility of changing meaning is always omnipresent in our next move (Lannamann & McNamee, 2011).

CHAPTER SUMMARY

In this chapter, we have discussed theories as discursive options as an alternative for dealing with the variety of therapeutic theories and models that exist. We presented how this concept focuses our attention on how different theories are created, and what kinds of conversations and effects they can create when used in real-life contexts. The focus is changed from content to process; from the "what" to the "how" of therapeutic practice. In the next chapter, we present the therapeutic focus on micro processes, and present how concepts and resources that come from different models can be useful in fostering generative therapeutic conversations.