

Therapeutic Heresies: A Constructionist-Relational Approach to Psychotherapy

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Relational constructionism begins with a simple but important idea: everything we consider real, all the truths that we cherish and the values we hold are constructed in and through the web of relationships that we participate in. When applying this idea to psychotherapy, we are invited to re-imagine and question its practices and traditions, particularly, those that have operated as unexamined truths or as a foundational logic in the discipline. This approach to psychotherapy may be considered a heresy when compared to traditional theories and models, that through their rigid standards and orthodoxies, and claims to objectivity and knowledge, have imposed an institutional order constraining the imaginative possibilities of therapeutic practice.

In this paper, I wish to explore the ways through which relational constructionism can help to release our imagination and creativity as psychotherapists. In it, I will make reference to the controversies, tensions, and uncertainty that are present within our practice and within our discourses. I will also suggest a view of psychotherapy that sees

therapist and client, as active co-participants in constructing the realities that emerge during the psychotherapeutic process. This approach stresses the importance of using conversational resources such as humor, curiosity, listening, metaphor, storytelling and improvisation, as a way to explore a client's narrative and generate new possibilities for meaning and action in his or her life.

Several of these conversational resources will also be included in the "telling" of my story of relational constructionism and psychotherapy. I include personal narratives, reflections and conversations with others, as part of my tale. Hopefully, this will enable a

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dialogue with the reader that may enrich and deepen his or her understanding of the ideas that will be discussed. I begin with a personal story ...

Discarding Flowers

More than thirty years ago, I began my clinical practice as a “psychosocial technician” in a mental health center in Puerto Rico, where I was expected to lead group, couple and individual therapy. I had recently graduated with a bachelor’s degree in psychology and had few other qualifications to perform psychotherapy, other than general readings in psychology and my own experiences as a client.

I met my first client filled with anticipation and anxiety. She was a 30-year-old woman who entered my office crying, anxious and concerned about the future of her marriage. She was convinced that her husband no longer loved her and came to therapy in order to prepare herself emotionally for what she believed would be the eventual break up of her relationship.

She told me she had been married for over a year and that she was deeply in love with her husband. She was distraught because his behavior during the last several months appeared to indicate that he was disinterested in their marriage. This, according to her, contrasted with his actions during the months that immediately followed their wedding. During that time, he seemed to be deeply in love with her. He called her at work several times a day and sent her a bouquet of flowers three or four times a week.

As she sobbed, she sadly stated that “he was now a changed person”. “His calls” she said, “had become less frequent” and now he called her “only once a day”. She paused and spoke sadly as her eyes swelled with tears, “Now, I only receive flowers once a week.” I asked her, if she had shared her concerns with her husband. She answered “yes”, and indicated that when confronted with her doubts, he insisted that he loved her as much as before. His strong denial, she claimed, just served to increase her distrust.

I proceeded to ask her general questions about her relationship. She insisted that they had no major conflicts and until recently, she had enjoyed the time she spent with her husband, as well as their sexual relationship. She reiterated, however, that because of the change in his behavior, she was afraid that something terrible was going to happen to their marriage, and that this made her feel strange and distant from him.

Listening to her story, I was somewhat perplexed and unsure on how to proceed. Looking for some kind of opening, I decided to ask her about her life and work environment. Her sobbing decreased as she described her job as a secretary and how much she enjoyed it. She also spoke of her many female friends at work. I asked her if they were married and if they felt loved by their husbands. She answered in the affirmative, and added that she knew this, because the quality of their relationships with their husbands had been a topic of conversation during her first months of marriage.

As I heard this last comment, I heard the voice of my own therapist resonating within with the questions he usually asked when I shared a particular story. Then, something changed inside me, I paused for a second and attempting to appear confused and perplexed asked her, “And what do they do with all the flowers in your office?” My client was momentarily stunned by my question and answered, “I don’t understand. What do you mean?” I responded, “Well, if your co-workers have wonderful relationships with their husbands, then I suppose your office must be flooded by telephone calls and the flowers that they send daily to their wives. I imagine that there’s a serious problem with organizing and discarding them. It must be a full blown operation, and I thought that in your office someone had figured out some novel solution for this. I was just wondering how they did it.” For a moment, she seemed more perplexed than before. Then a slight smile appeared on her face before she asked me, “Are you kidding?” I answered, “No, I’m very serious about this. I’ve thought about

working as an organizational consultant and thought that the solution might be helpful to me in the future”. She stared at me for a second and then began laughing. Then, she asked me, “Are you trying to tell me that I’m worrying needlessly.... that my husband, as well as other husbands, has his own way of expressing his love?” To which I answered, “Well, I don’t know if that’s the case, but what I think really doesn’t matter; what matters is what you believe. What do you think?”

From that moment on, the tempo of the conversation changed. We began to reflect together on the events and meanings of her initial story. We explored whether there were any other reasons that would lead her to worry about her relationship with her husband and if there were conversations with him that she needed to engage in. We talked about her dreams for her relationship, her professional goals, and the importance of communicating and affirming herself in her life. When the session was finished, she thanked me and told me that she would contact me if necessary. I never saw her again, but a couple of months later I received a letter thanking me for my services.

Through the years I have shared this story with students and colleagues. The responses have been varied. Some have been surprised by the ingenuity and the luck of a novice therapist. Others have been more critical. They’ve questioned a therapeutic strategy that did not diagnose the disorder that the client suffered. This, they’ve reminded me, should have been one of my priorities. Several colleagues of a more cognitive persuasion have argued that I should have been more systematic in my approach, helping her to identify her cognitive distortions and teaching her to substitute them with more rational ways of thinking. Others have thought that my approach was too superficial. Problems like the one she portrayed they’ve claimed, are often indicative of a complex disorder. They’ve suggested that her obsessive preoccupation with the loss of her husband’s love functioned as a symbolic representation of an unresolved psychic

conflict with her father. They pointed out that what I did probably just helped to suppress a symptom that would reappear in the future, perhaps in a more virulent fashion, since what caused it in the first place had not been resolved.

Each advice that I heard, if applied, would have taken my conversation with her in a totally different direction. It would have produced different questions and interpretations. A new story would have probably emerged. What would have been considered important, significant, or problematic, would have been defined differently according to the personal and theoretical framework which I would have utilized.

This anecdote and the responses to it, points to the multiple ways that therapist and client participate in the constructions of the “realities” they encounter in psychotherapy. It illustrates how what we as therapists listen and seem to “discover” in psychotherapy are not de-contextualized realities or stories. We co-create them with our clients through the way our conversations, body language, dramatic and emotional expressions, questions, affirmations, and silences construct a conversational “dance” through which a client’s story is told and heard.

Relational Constructionism

This view of psychotherapy as a place where stories are co-created is founded on a relational and constructionist concept of social reality. This approach stresses that meaning doesn’t lie inside or outside the individual, but rather develops in and through our relationships with others. It affirms that what we know, and our ethics and morals are constructed through our participation in the social world and the communities and traditions to which we belong. It sees human beings as active agents who construct the social realities in which they participate. These constructed realities guide and provide meaning to one’s own actions and the actions of others’ (Botella, 2006; Gergen, 2007; Hosking, D., 2007).

From the perspective of relational constructionism, stories and narratives are the means used by human beings to generate meaning. They serve to construct order in a changing and sometimes chaotic world where a clear course of action is not always evident. Stories and narratives give substance to our experiences, placing and organizing them in temporal space. They help us to explain events, to relate one experience to another, while generating a sense of coherence and continuity in our lives. (Cotter, Asher, Levin & Caplan, 2004; Botella, 2006).

Our stories are constantly evolving and changing according to the ongoing experiences and relationships in our life. There is not one story or narrative that defines us, or that is permanently static and fixed in time (Cottor et al, 2004). They are not products of isolated selves but instead, are social creations that are generated through the relational networks that we maintain throughout our lives. Each story requires a narrator and an audience that listens and responds to it. The dynamic relationship between narrator, narrative, and audience transforms a particular narrative and converts it into a co-created product and a form of relationship through which we generate meaning and elaborate a particular social identity (McLeod, 1997).

The “self” appears as another character in the collection of stories which we narrate. It emerges as a construction that is produced and reproduced in the context of the multiple relationships in which we engage. For the perspective of relational constructionism there is no such thing as a fixed self, or a particular essence that defines the “individual self”. Instead, the “self” is seen as a “community of selves” that emerges thorough our relationship and participation in different social contexts. Therefore, it can’t be said that we speak from one identity and through one voice. “We are all comprised of various voices that reflect our participation in different social and relational contexts, voices that; if not identical do configure a polyphony that contributes to the

final product” (Botella, 2006, p. 30). As poly-vocal beings, we have the capacity to speak with different voices, from multiple perspectives and points of views.

These assumptions about the self are not proclaimed as a new truth. Doing so would be contrary to the ideas held by relational constructionism, since it would presuppose that an objective reality exists that can be grasped and understood by a set of concepts and practices that operate independently of their historical and social contexts. Instead, relational constructionism assumes that when a new truth is proclaimed and a given course of action is seen as morally correct, it reflects a particular cultural tradition in the context of a specific form of relationship or way of life (Gergen , 2007).

Assuming that reality is relationally constructed does not preclude advocating values and positions or proposing rules and guidelines to coordinate actions and regulate human activity. When engaging others we need to speak, choose and act to satisfy shared and personal interests, as well as address controversies, dilemmas, and conflicts that may part of social discourse and interaction. Our actions, however, can be tempered by the understanding that any value or declared truth is situated in a particular historical and communal context and therefore, there is no ideology, tradition, or way of knowing that represents a universal truth or has an intrinsic normative power.

This stance promotes what Gergen and Gergen (2004) have called a radical pluralism, an openness in the social discourse to the multiple forms in which we can value or attribute meaning. Radical pluralism frees us from the need to decide which tradition, ideology, or ethical or moral proposal represents the “truth”. It favors social practices based on dialogue and respect for diversity. It also promotes the emergence of discordant voices, and the curiosity to explore and understand the role that these play in the communities and traditions from which they emerge.

Relational constructionism invites us to pragmatically and critically reflect on our everyday lives, on the values we hold and the actions we take. In a constructed world, any action or belief is seen as only one way, amongst many, of engaging or valuing social reality. Therefore, rather than evaluating whether a specific argument or pronouncement is true (that is, if it is a precise representation of reality) it favors examining the implications of what is being advocated. We can ask ourselves, for example, what practices or bodies of knowledge are privileged and which are being suppressed or marginalized by the “truth” I’m being asked to hold? We can question what traditions are honored and which are being discarded in what is being promoted by what is being said or by what is being written? We can also reflect on the world that is being created by a particular social discourse and whether it is the type of world we would want to live in. (Gergen and Gergen, 2004)

This stance towards living promotes a type of sensibility and social practice that sharpens our critical awareness and generates new possibilities for dialogue and social coexistence. It provides a generative framework for exploring and enriching our capacity to understand and for action in the midst of a poly-vocal world . (Gergen and Gergen, 2004; Botella, 2006.)

Psychotherapy and Relational Constructionism

Relational constructionism is not a model for doing psychotherapy instead. Instead, it proposes a stance for engaging psychotherapy. It invites us to rethink and reconsider the practice and traditions of psychotherapy, as well as the ways through which the realities that clients and patients experience are co-constructed during the psychotherapeutic encounter. In rethinking psychotherapy, it also seeks to challenge taken for granted practices that may serve as unquestioned blinders that restrict the capacity of its participants to perform sensitive, spontaneous and/or regenerative action.

For example, a core component of modern psychotherapy is the practice of diagnosis. Diagnosis has been seen as a necessary step for understanding and explaining a client's problems and for designing and initiating treatment plans. Its terminology has been sanctioned by the managed care system and is required for billing. As a social practice, it positions the therapist as an expert observer, tasked with questioning and examining a client (who is assumed to be in some way deficient and needs help), in order to comply with a pre-established agenda of locating the individual's dysfunctional condition within a set of pre-established categories.

Diagnosis may comfort a particular client because it may provide him or her with the hope that by naming a clinical condition, a problem has been identified and a treatment leading to a solution can be implemented. However, from a relational constructionist perspective there is much to challenge and question regarding the unexamined assumptions of its practice, as well as the view that it purports of psychotherapy and the psychotherapeutic relationship.

Diagnosis is part of the modernist tradition in psychotherapy. It assumes that there is a truth value in the assertions of those that are thought of as objective observers. In its attempt to mimic the medical sciences, it holds that human action and experience, like biomedical conditions, can be explained and predicted through observation and the mapping of cause and effect relationships. In doing so, it locates the causes of dysfunctions within the individual, thus, negating the impact of social context and discourse on a client's narrative and lived experience. (Gergen, K; Hoffman, L. and Anderson, H., 1996)

Relational constructionism assumes that psychotherapy is a particular type of relationship that is embedded within a specific cultural and professional tradition and discourse. It also supposes that the way this relationship is framed and performed by its

participants generate the realities that are lived and experienced during the psychotherapeutic process. When one views the practice of diagnosis from this perspective, one can begin to explore and question the degree to which the hierarchical nature of the diagnostic relationship, where one participant stands from a position of institutionalized power in judgment of the other, shapes the relationship between them and influences the realities that are being described and categorized.

With its medical jargon and deficiency based language, diagnostic discourse has served to privilege a view of social life that stigmatizes personal identity. It is a discourse based on incapacity and illness. In this manner, it constructs a relational world in which the person's deficiency is the main topic of conversations in therapy and his or her principal reality. This practice, taken to its extreme, blends the client and his or her problem into one single entity: the psychological disorder. This in turn reinforces the person's idea that not only is something wrong, but that which is wrong in the client is him or herself.

A diagnosis can also bestow a social identity based on dysfunction and incapacity. In as much as its language has penetrated social discourse and has been disseminated throughout society, it has created a population of consumers of psychological services that demand the intervention of knowledgeable professionals to provide appropriate cures. (Gergen, K; Hoffman, L. and Anderson, H., 1996)

The practice of diagnosis has served to reaffirm the idea that psychotherapy is a techno-medical project where "a human being is a machine and the therapist a technician that works with faulty human machinery" (Anderson, 1997, p. 67). In doing so, it has contributed to a discourse that seeks to eliminate uncertainty and inventiveness from the practice of psychotherapy and is in part responsible, for the recent trend in psychology that has insisted that all psychological practice be based on empirical data gathered

through the implementation of experimental clinical trials. This stance has privileged the use of manuals and standardized procedures to treat specific life problems and mental disorders, as they appear in the DSM-IV.

Relational Constructionism positions itself against attempts to standardize and homogenize the practice of psychotherapy. In doing so, it proposes a view of diagnostic practice that considers it as just another relational move within the context of a social relationship, which we call psychotherapy. It also sees it as a mode of languaging a particular form of relationship which has been legitimized within the context of a specific professional tradition. It questions the truth value of the assertions and methodology used to produce diagnostic categories and locate clients within them. In questioning the practice of diagnosis, a relational constructionist stance examines the kind of identities and social relationships that are created through the diagnostic discourse and whether the therapeutic realities that it generates lead to more engaging and fulfilling lives, for those labeled. (Gergen, 2005)

Relational constructionism frees us to re-imagine the practice of psychotherapy and explore the possibilities generated by our images of its practice. We need no longer to think of it as a “treatment”, a scientific procedure or a place to acquire an expert’s knowledge. Instead, we are invited to envision psychotherapy in more relational ways, as a form of dialogue or conversation that aims to expand the resources available to the client, so as to enable and generate new histories, realities, and possibilities of action and meaning (Gergen, 2005; Botello, 2006)

This approach assumes that what happens in therapy is a product of a relationship that is constructed in a specific social context. There are no particular standardized practices or procedures that need to be followed or a specific identity that the therapist needs to assume. In this sense, what a therapist does and who he or she is, can take

different forms according to the particular relationship that he or she establishes with a client. This position assumes that the therapist and client can collaborate together in defining and negotiating its purpose and goals. They each enter the therapeutic encounter with different kinds of expertise in specific domains in their personal and social life. The client in particular, can be seen as possessing important knowledge that enables him or her to evaluate and decide what is meaningful and what to share within the context of psychotherapy. (Anderson, 2007).

Living in a constructed world frees psychotherapists from the burden of having to determine whether the assertions made by a particular model of doing psychotherapy are “true” or not. Instead, it generates openness towards the use of diverse methods and/or psychotherapeutic languages that may serve the aims of the therapeutic encounter (Elkaim, 1997). This means that rather than engaging psychotherapy from a stance that prescribes a set of techniques, or a fixed position or identity from which to act, it approaches it with a more pragmatic orientation. It examines the consequences that different forms of relationships and the conversational moves of each of the participants have on the therapeutic process. In this sense, all actions are open to review. Instead of referring to theoretical cannon in order to determine how to proceed, a therapist may choose to examine the effectiveness of his or her actions. He can explore, for example, whether they have potentiated or hindered dialogue or forms of life that support the negotiated purpose of psychotherapy.

In regards to the clients’ discourse, relational constructionism assumes that a particular narrative does not represent a literal truth but instead, is a contingent construction in whose creation participate client and therapist. It also contends that the stories that are initially told in psychotherapy are not the only ones capable of being spoken. This implies that the official story, the one that generates and confirms a client’s

problematic identity and which is often saturated with difficulties and hopelessness, is only one amongst multiple narratives that a person may use to signify his or her life. Viewed from this perspective, the therapeutic relationship becomes the context where new alternative and hopeful stories may be co-created. They may be built from voices that have been suppressed or ignored and that hold within them the capacity to make new meanings and courses of action possible. (Gergen, 2005; White, 2007).

The creation of new narratives and resources for action is generated in the context of a conversational process that often places the therapist in a “not-knowing” position and requires what has been called in Zen practice, a “don’t know” or “beginner’s mind.” This is a type of a relational presence that acknowledges the uncertainty inherent in life and which seeks to face any situation with openness and without attachment to preconceived ideas, interpretations, or judgments. (Suzuki, 1973; Mitchell, 1976)

In the context of psychotherapy a stance of “not knowing” implies, among other things, an acknowledgement that its participants cannot predict with certainty the path that will be taken as a conversation proceeds. How someone will respond to a particular conversational move can never be predicted with absolute certainty. How conversational moves are interpreted redirect the conversational dance in psychotherapy in different and often unexpected directions.

“Not knowing”, therefore, implies living with uncertainty and becoming sensible to what McNamee (2003) describes as the “interactive moment”. It becomes a relational space where therapist and client become equals, because neither knows how each succeeding moment in psychotherapy will unfold. It is also the place where psychotherapy becomes “art”, where the therapist has the opportunity to use his or her imagination and intuition to improvise and explore different opportunities and options of relating and interaction. It is a moment where one can listen to the different voices that

serve as “internal companions” (friends, mentors, therapeutic models, family, colleagues, alternate identities) and make use of available conversational resources to deepen the dialogue and generate unforeseen paths in the therapeutic relationship (McNamee, 2003).

In summary, a therapy informed by a relational constructionist sensibility, positions the therapist in a reflexive and open relationship to the practice and traditions of psychotherapy and allows him or her to explore the conversational possibilities inherent in the therapeutic dialogue. It cultivates a presence that includes and acknowledges multiple voices, perspectives and identities in therapist and client, and uses them as dialogic resources that can enable a client to deconstruct what is problematic and re-imagine that which is possible.

Relational Practices

I have outlined the implications of approaching psychotherapy from a relational-constructionist sensibility. I now wish to examine three modalities of relational practice that illustrate the possibilities of action that it can generate in psychotherapy.

Opening a Dialogical Space

A first group of relational practices have as their aim the creation of an open ended dialogical space in the client-therapist relationship that enables a process of shared inquiry to occur. This space is generated in part, through the practice of deep and sensitive listening that brings a sense of curiosity and an interest for capturing and understanding the client’s experiences and narratives in their full complexity. Listening includes and transcends the ability to quietly pay attention. It implies a way of inquiring, representing and dramatizing what has been grasped in ways that reverberate with the felt experience of the client and is recognized by him or her as an accurate depiction of his or her experience.

Synchronizing and paying attention to different dimensions of language and human communication may also help to generate a dialogical space. This may mean, for example, becoming aware of the way in which the client makes use of corporal expressions, gestures, movements and modulates his or voice to communicate and signify his or her experience. This sensibility allows the therapist to synchronize and adapt his or her communication to the spoken and unspoken language and rhythms of the client. It also allows him or her to step into a person's shoes, imagine the world from the client's perspective, and represent dramatically and with feeling the experience of the client so as to demonstrate that he has grasped his or her story in its full complexity.

Conversational resources such as drama and metaphor may be used in the service of connecting with the felt experience of the client and creating a context where client and therapist can begin to relationally engage with each other. They can become useful tools of relating and moving into the experiential world of the client in ways that can engage him or her and open up the possibilities of dialogue.

The Cat Lady

Several years ago, a young, 18-year-old woman, who had been diagnosed as a paranoid schizophrenic, was referred to me. Her prior therapist had informed me that the woman heard voices and, on occasion, had acted aggressively in her home, using scissors to cut and shred her clothing in front of her amazed parents. He also claimed that she had been an unwilling and unresponsive participant in psychotherapy. According to him, her only meaningful relationship was with a small white cat that she played with and talked to at home.

The young woman arrived with her parents at the community mental health center where I worked. She entered alone into my office and sat in a chair beside a desk in the room. AS she sat, I was able to notice how her make-up intensified the paleness of her

skin and contrasted with the intense redness of her lips. Her gaze was fixed but seemed lost in space. This made me wonder how I was going to approach and engage her in conversation. I began with the introductory rituals which are common in our profession. I stated my interest in talking with her and helping her. I asked her for her name, the reason she had come to my office, and whether there were any concerns that she would be interested in sharing with me. She responded to each question with silence and an immutable physical expression. During the next few minutes, I attempted different strategies to initiate a dialogue but all of them failed. She remained resolute in her refusal to engage me in a meaningful conversation.

I felt frustrated and confused, with few ideas on how to proceed. Then, I remembered the words of her former therapist and his comment about her relationship with her cat. At this point, I changed the tone of my voice and softly mentioned that like her, I had a small pet kitten. To my surprise, her right eyebrow lifted. For the first time, I had received a response that recognized my presence in the conversation!

I decided to continue talking about the kitten. I described some of his habits and personality traits. She responded to each piece of additional information with a change in her facial expression which I interpreted as a sign of interest and curiosity in what I was sharing. I then decided to take a risk. I mentioned with excitement, that my kitten was very mischievous and had a habit of interrupting me in the most inopportune moments. “For example,” I told her, “this morning, while I was doing my homework at my desk, the kitten came near to where I was sitting, looked at me with her big eyes... and you know what she did?” I paused for a second and then suddenly jumped on top of the desk. I stood on four legs like a cat and then while fixing my gaze on her, I began to meow loudly like a kitten. Completely surprised, she remained silent for a moment and then exclaimed, “You’re crazier than I am!” To which I responded, “Yes, but unlike you, they

pay me to be crazy.” She sat in silence for a second or two, then, suddenly she looked at me with an impish grin and began to laugh heartily. She then calmly said, “With you, I can talk.”

This story illustrates the range of conversational resources available to the therapist when he or she lets openness, dialogue, and acknowledgement of the other serve as a guide for his or her practice. It demonstrates how even unusual modes of communication can be used to develop the relationship between therapist and client. It also promotes a relational stance that seeks to engage the client in a shared language that transcends rigid prescriptions about how to proceed in therapy. The therapist maintains a reflexive awareness of a relational space that includes him or herself and the client and particularly, those moments when something different or new occurs in the conversation. Those openings, which can be missed if awareness and sensitivity are missing, allow the therapist to invent and engage in innovative forms of relationship and explore relational spaces that make collaboration, dialogue, and transformation in psychotherapy possible.

Co-creation of Competences and Abilities

Exploring these alternative spaces of relationship leads us to a second group of practices that are fundamental to a relational constructionist approach to psychotherapy: the co-creation and acknowledging of competencies and abilities. These practices are founded on the assumption that clients have abilities, strengths, and resources that if recognized and acknowledged may help generate new constructive ways of solving problems, finding meaning, and re-imagining their lives (Bertolino and O’Hanlon, 2002).

The idea that our clients are competent and capable human beings redirects the psychotherapeutic conversation through paths not envisioned in a deficit based discourse. It moves us into experiential spaces where the person can acknowledge talents and capacities that are ignored in the problematic identity that has been shaped through his or

her official story. It generates a conversation that includes not only what is going wrong but also what is going well, and explores not only what is limiting and generates suffering, but also what strengthens and generates meaning. This perspective acknowledges that, although the person may have problems and that his or her action can have undesirable consequences, he or she is not the problem (White and Epsom, 1990).

There are multiple practices for attending and co-constructing competencies in psychotherapy. For example, narrative and solution focused and competency based therapists suggest asking a client directly for experiences in their lives that illustrates strengths and abilities or where they've demonstrated their capacity to face obstacles, solve problems, and reach their goals. (Bertolino and O'Hanlon, 2002; Walter, J. and Peller, J., 1992; White, M., 2007) Bertolino and O'Hanlon (2002) also suggest reframing deficit based descriptions to "normalize" what has been designated as pathological or faulty. For example, hyperactivity can be re-signified as being filled with energy, and having oppositional traits can be re-conceptualized as dissidence or the conviction and willingness to defend one's interests when subjected to pressures by those in positions of authority.

Discovering competencies, however, is not dependent on a particular technique or a form of questioning. A therapist can assume a mode of listening and participating in a conversation where he or she is constantly looking for opportunities to frame life experiences and client traits as examples of strengths and abilities. For example, as he or she listens, he or she can consider, "How can this expression, this relationship or form of life referred to by the client, can be seen as a strength? How can it be used as a resource in psychotherapy?"

The following narrative of one of my clinical students provides an example of how attending to, discovering and co-creating competencies in a therapeutic relationship can help to transform a client's identity and modes of relating and acting in the world.

Wild Rose

Rose was a 50 year old woman who was referred to psychological services by a counselor from a Government Vocational Rehabilitation Program because she had difficulties "verbalizing her problems or needs". She also had a stressful life situation because she was unemployed and had to care at home for a severely disabled daughter. The program had also requested that a psychological assessment be conducted in order to assess her "intellectual capabilities so that she could gain entrance into a vocational program." This assessment was to be done another therapist.

When I asked her questions about her life during our first conversation, she started to speak but would stop, begin gesturing with her hands and head as if saying "no" and then would state "I don't know how to say it, I'm stuck". This cycle of communication was repeated several times during our initial meeting. I sensed that she was tense and fearful of whatever it was that she thought I was there to do. I then began asking her questions about everyday activities hoping it would make her feel more comfortable and allow me to gain her trust. This approach opened up our conversational space and she began to articulate her story.

Rose spoke about her difficulties in relating to others and about the impact of having been labeled "mentally retarded" at an early age. She said that people told her she couldn't do things because she was "stupid" and that she was reticent to talk to others for fear of being ridiculed, so she felt very alone. The thought of undergoing a

psychological assessment increased that fear because she anticipated that the results of the tests would deem her incapable of working in any job.

When we engaged in “non-clinical talk”, I discovered that she had a particular fondness and talent for gardening. It was an activity that she carried out every day especially, when she was feeling stressed or alone. Upon hearing this, I decided to mention my lack of talent for tending to plants and told her that all of my houseplants had died because I could never tell the correct amount of water to use, or when they needed watering, and whether a particular plant should be indoors or outdoors, among other things. She then began explaining all of the different ways that plants “told” us what they needed. Changes in color signaled a need for more or less water; texture and composition of leaves could “tell you” whether a plant needed to be indoors or outdoors. When I asked her how she knew all of these things, she mentioned that these were things she learned only through the experience of having plants and caring for them in her home. As she continued to share with me her knowledge of plants, I noticed that she was very comfortable and articulate. There was no hesitation or “verbal difficulties” when plants and gardening were the subject. We had found, through the course of the conversation, a “language” that she was very fluent in!

When I shared this experience with my supervisor, he suggested that I explore other identities besides “being the therapist”. He asked me to let her be my teacher, so that I could learn about plants and their “hidden language”. He also reminded me that her relationships with plants could operate as a living metaphor for her relationship with herself and her own life and could be used as a conversational resource for transformation.

As I began to relate to her as my new mentor, I discovered that through the use of plants and gardening metaphors she was able to express her emotions about

different situations or the problems that she was experiencing in her everyday life. For example, when speaking about lacking a sense of order she compared herself to “a bunch of weeds growing wildly in a yard”. When referring to her daughter she would say “she is like an orchid, very beautiful but very fragile”. When describing how she felt people viewed her, she said she thought they saw “a cheap carnation” but that she felt like a wild rose because “she was beautiful once you got past all of the thorns”. She also compared the ways she felt when she spoke to plants to how she approached speaking with people, something, she said, made her very uncomfortable. By highlighting the different relationships she established with each particular plant and what worked with them, we were able to explore and generate new ways through which she could put those abilities to use when speaking and relating to others.

Talking about plants, also allowed us to explore the apprehension she felt towards the psychological assessment that she needed to undergo in order to qualify for the Vocational Rehabilitation Program. Her concern, she stated, was related to the rejection she had felt in the past by others who deemed her “retarded”. Our relationship however, had given her an experience of relating as an expert with a “professional as a student” and thus, she had gained a sense of competency, a sense that she described as the confidence “that I can do things”.

Once she could affirm herself, we began to engage in conversations about times and domains in her life where she had been successful (graduating high school and as an exemplary mother who took care of a severely disabled daughter, for example). This shift in focus allowed her to recognize that she, like other human beings, had different strengths and weaknesses. This understanding undermined the narrative that had placed her as being “less”, “stupid” or “not as knowledgeable as others”. This, in turn, generated unanticipated possibilities for future development.

Before ending therapy, we co-created a plan that built on her strengths and that she could use to participate in new activities and social situations, as well as prepare for a future job in gardening.

I later heard from her rehabilitation counselor that she had enrolled in and successfully completed a program where she was certified to do gardening work. The counselor was surprised to find out that the woman that had been plagued with so many difficulties now seemed changed and transformed. In her conversations with him, this “new woman” he said, “constantly reminded me that she had a talent and passion for something that not everyone could do”! (Soliz-Baez, 2009)

This story illustrates a way of doing therapy that invites a person to reconsider his or her life from positive and change promoting perspectives. New stories that stress vitality and meaning can be co-constructed. Through these new stories, events may be re-signified, forgotten narratives can be restored, and experiences that reflect a person in more meaningful ways can also be explored. In this way, a client can participate in the creation of narratives that assert his or her strengths and capacity to rethink and re-evaluate his or her past and future.

Reaffirming what is best in a person does not imply a new, repackaged version of positive thinking. This practice does not privilege a particular way of thinking or being. Neither does it deny that there is suffering and hurt in life. It refuses, however, to privilege perspectives that have turned naming and explaining what is dysfunctional as one of the unquestioned needs in psychotherapy. Instead, it proposes an alternate approach to therapy that acknowledges the human potential to reinvent oneself, to overcome suffering, and to act in accordance with one’s most noble aspirations.

The Crisis of Faith

Clients' troubled stories are often saturated with suppositions and experiences that operate as truths and natural realities. In order to question these, there is a third group of relational practices whose goal is to provoke a crisis of faith in the client's beliefs and ways of relating which help to maintain problematic narratives and identities. They seek to "demonstrate and experience the constructed nature of concepts we take as a given" (Botella, 2006, p.30), and destabilize and break the perceptual "curse" through which an identity, a way of relating, or a problematic story are assumed to be the only possible reality. They also maximize opportunities for breaking down the foundations of any assumption, belief, or idea that taken as an absolute truth has served to limit the ability of a client to re-signify his or her story and/or generate a more hopeful and enabling narrative.

In attempting to provoke a crisis of faith, a therapist takes advantage of inconsistencies that may appear within a particular discourse or alternate identities and narratives that don't form part of the official story. Different conversational and relational resources, such as reflective dialogue, hyperbole, paradox, challenge, humor, analogy, metaphor, and story, may be used to generate a crisis of faith. Different dramatic modalities such as role-playing real and imaginary figures can also be employed.

Using these resources requires that a therapist be able and willing to alter the expression of his or her identity in ways that allow him or her to adapt to the changing conditions of his or her relationship with the client. This implies, for example, that on occasions, a therapist may assume an identity that expresses empathy and compassion, while at other times he or she can become an incisive and persistent inquirer. The

therapist can also become a storyteller, perform multiple dramatic roles, and make extensive use of metaphor and humor (Gilligan, 1997).

By not maintaining a fixed identity, the therapist turns into a form of audience that can respond in unusual and unexpected ways to the client's stories and ways of relating. This makes him or her unpredictable and difficult to place. The client's narrative and dramatic expression may be left without the audience and the form of relationship needed to maintain it. This may provoke alterations in the client's identity and mode of relating in order to respond to the new relational context where the story is being told.

A crisis of faith can occur when client and therapist collaborate together in accessing realities and perspectives that undermine the beliefs and ideas that sustain the client's official story. This may require the recall and exploration of experiences that have been marginalized and discounted as a strategy to undermine the truth that hold the client's imagination in captivity.

The Community Organizer

Several years ago, a client who worked as the administrator of a community based enterprise, asked me to meet her in her office in order to deal with a personal crisis. When she called, she was in a heightened state of anxiety. She had been weeping locked in her office for more than two hours. That afternoon, the Board of Directors of her organization, was holding an emergency meeting that required her presence. She was concerned, that because of her emotional condition she would be unable to attend. When she asked me for my help, she told me, "I don't think I have a way out. Given how I feel, I can't possibly be at that meeting in two hours."

When I arrived at her office, I found her inconsolable, repeating over and over again: "I have no future"; "My life is over". When I asked her what was wrong, she told

me that during the last few weeks, a regional newspaper had been publishing a series of articles that questioned her organization's business practices. In an article that appeared in that day's newspaper, she had been accused of corruption and of using the organization's deposits for personal gain. She maintained that all the information was false and that the reporter had never interviewed her to corroborate the charges that appeared in the article.

I listened to her attentively, while she explained how she felt ashamed and humiliated. She was worried that her grandmother and daughter, (whom she had raised as a single mother), would read the newspaper and think that she had been engaged in criminal acts. She was also concerned about her professional reputation and her standing in her community. Full of sadness, she lowered her head and broke into tears. Then she added: "What's worse is that the only thing I hear in my head is the reporters 'damn' voice, accusing me again and again of being a thief... I just feel there's no way out."

As I listened to her for the next few minutes, I remembered several of our previous conversations and her history as a community leader and a responsible single mother. I waited for a moment of silence. Then I asked her in a paused and dramatic tone, "I understand you can hear his voice, but I wonder if you can listen to the other voices." She looked at me with a perplexed gaze and asked me, "What voices are you referring to?"

"Your grandmother and your daughter's voices..." I paused for a few seconds before going on. "If they were to stand here, in this office and saw you crying, would they speak to you as he does?" "Would they say the same things?" I paused again, giving her a moment to consider my question. I then went on, speaking carefully and slowly. "I don't know if you can listen to their voices.... I don't know if you can notice and feel the way they would approach you."

She stopped crying and answered, “They would give me support. They would say they love me and my daughter would hug me.” Then, I asked, “Now, that you can see their loving eyes, and listen to their words and feel your daughter’s arms around you... how does that make you feel?” “A lot better” she answered.

By now, her breathing had changed and had become deeper and fuller. I continued, attempting to engage her through my words. “I know you can already listen to their voices, but the one that’s here is in crisis. There are other voices that are needed. “ Curious yet puzzled she asked, “Who are you referring to?”

I answered as if it was obvious, “Well, you know the others....the woman that overcame all kinds of difficulties through her own efforts, the one that raised a daughter and took care of her grandmother. Is she here? Can you hear her? ” I paused for a few seconds, long enough to notice that her eyes were no longer reddened by tears. “Then there is the community leader, the one who helped the elderly, students, and the poor ... Is she here? Can you listen to her?” Again I paused. “And then there are the thankful voices, the others that have blessed you in their prayers. Are those voices here with you? Can you listen to them? Can you feel them as they speak to you and remind you?”

The change was already noticeable. Fragility gave way to determination and confidence. Then she said, “I feel as if I have all of them here with me, talking to me, giving me support. I had forgotten I have a lot of people on my side.”

This was the beginning of a fruitful conversation that helped her to reconsider the many “truths” that she had taken for granted. She discovered, for example, that the reporter’s voice was one among many voices that she could listen to. When she began our conversation, there only existed two voices in her conversational space, her accuser’s and the one who belonged to a woman isolated and weakened by his accusations. Through our dialogue, other voices, identities, and points of view emerged that

questioned the realities she had taken for granted and helped reaffirm her worth and gave her back her sense of purpose.

This example dramatizes the way through which the therapist and client can participate in deconstructing and co constructing the realities in psychotherapy. Through listening and communication, the therapist acknowledges the importance of what the client feels. He uses different ways of speaking to generate a dramatic intensity and capture the listener's attention. Through use of questions and suggestion, other social realities emerge. The client enters a world where families, friends, and colleagues join together as a supportive and affirming imaginary community that enables her to question, reconsider and re-imagine her situation.

Each of these relational moves acquires meaning in the nexus of the relationship with the client. As a therapist, one is led by what one listens to and the way the client responds and attributes meaning to what one does. In this case, the client accepted an invitation and collaborated with it. Through words, silences, and gestures a conversational dance was created. The co-created language of words, silences, gestures and body movements made it possible for the client to question what had once seemed like fixed and unalterable realities. Through that language, an alternate identity that generated new possibilities for action was forged. It allowed this client to access and rely on a community of imaginary presences and relationships to re-signify and discover her strength in the face of what once seemed to be a serious and insurmountable threat to her personal integrity.

Final Observations

I have presented a view of psychotherapy founded on the constitutive power of language and human relationships which conceives psychotherapy as a conversation, in which the therapist and client participate in the co-construction and re-construction of

pasts, presents, and futures. I have also suggested that these realities are ever changing and uncertain. That is to say, we never know exactly what awaits us in the conversations we hold in psychotherapy and what meanings will be generated through them. In facing uncertainty, I have suggested the importance of being sensible in the interactive moment, because as Gergen (2005) states, “We never know when or how a door will open (if it opens) into another better way of living (according to a certain point of view).” (p.174)

Acknowledging the constitutive power of language has important implications for the therapist. It makes him or her question forms of language and relating that generate realities which incapacitate and restrict the ability for reinvention. It also leads the therapist to undertake practices that open up new possibilities of relationships and re-imagination. I explored three of these in this text and, through examples, illustrated ways in which they may be used. These, however, are only a few of the many of dialogic options that therapists may access when he or she relates from a stance that acknowledges the participatory and co-constructed nature of the realities that client and therapist live, in and outside of therapy.

In concluding, I wish to borrow Gergen’s (2005) proposal to re-conceptualize psychotherapy. He suggests that instead of using a language based on mechanics and cybernetics to describe psychotherapy, we are better served by the use of a more imaginative and literary approach in our conversation. He challenges us to re-imagine psychotherapy as a literary form that can be founded on three characteristics of poetic language: the capacity to scrutinize what is common and ordinary, to make the imaginative credible, and to generate an aesthetic sense in the relationship between client and therapist.

Gergen’s proposal synthesizes the essence of what I have shared. It invites us to re-imagine psychotherapy and our work as therapists. It suggests that we free ourselves

from orthodox clinical chains that, with their deficiency based language, prescriptions, and pretensions of control and prediction, transforms psychotherapy into a technical activity that lacks imagination and soul. It proposes a vision that empowers the client and makes them a participant in the co-generation of realities that are re-invented through the psychotherapeutic dialogue. It also invites us to use our imagination to participate in a poly-vocal and pluralist world, where our relation to the unknown and the unforeseen generates mystery and enables the possibilities of creation. Listening to, immersing ourselves in experiential worlds, questioning and destabilizing, generating alternate futures, and establishing a certain aesthetic in our ways of conversation and interaction, all are part of the rich tapestry and dance we call psychotherapy. Therapist and client speak together to reconsider the old and reinvent the new, to re-imagine and generate as Gergen (2005) says, “a discourse of dreams, a discourse that believes in the image of what is to come, of a hopeful, stimulating and captivating future.” (p.81)

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