

Who is the Therapist?
A Social Constructionist Exploration of the Therapeutic Relationship

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Perhaps the most useful way to enter into a conversation about the therapeutic relationship and the role of the therapist is to address what I see as a central issue in discussions of social construction as it relates to the **practice** of psychotherapy: *What does constructionism offer in the realm of practice? What do we do, as therapists, once we propose that meaning emerges in the on-going flow of persons in situated activity? And thus, what are the implications of this form of practice for the therapeutic relationship?*

Let me begin by talking about social construction as a **philosophical stance**, rather than as a model or method for psychotherapy. Social construction offers us a “stance” for engaging in the therapeutic relationship as well as a way of expanding our understanding of what we mean by the therapeutic relationship. When we talk about *therapy as social construction*¹ we are not emphasizing a particular technique or method but rather a way of thinking about therapeutic process. If therapy, from a constructionist orientation, is a conversational process (e.g., not “social constructionist therapy” but “therapy as social construction), then what can we say about

¹ My 1992 volume, co-edited with Kenneth Gergen, is purposively entitled, *Therapy as Social Construction* rather than *Social Constructionist Therapy* to indicate our focus on a stance or orientation with which we approach therapeutic process as opposed to a focus on any specific type of therapy (e.g., a model). As constructionists, we are interested in exploring therapy (and any other context or phenomena) first and foremost as a conversation wherein realities are crafted.

the relationship between the therapist and the client? Before addressing this issue, I will sketch the individualist tradition in psychotherapy because in doing so, constructionist features of the therapeutic relationship can be more clearly articulated.

Traditions of Psychotherapy

Like any other cultural institution, psychotherapy, is imbued with a wide range of expectations. One insidious expectation is the idea of a deficiency or weakness *within* the person. Psychotherapy is infused with this notion of an individual's failure in some domain regardless of whether we are talking about marital problems or psychosis. Although the therapeutic process is often justified on the grounds of its empowering the otherwise infirm and dependent, there is an important sense in which the reverse is true, and in which diagnostics are a chief vehicle for disempowerment. It is in the works of Michel Foucault (1973) that the logic of disempowerment becomes most clear. In Foucault's terms, when we offer ourselves for examinations of various sorts we are giving ourselves over to the disciplinary regimes, to be labeled and explained in their terms. And when we carry these terminologies into our daily lives, speaking to others of our depression, our anxiety, we engage in power relations - essentially extending the control of the disciplinary regimes. As our disciplines of study begin to influence public policy and practices, we become further ordered in their terms. As diagnostic terminology is increasingly sanctioned by managed care systems, so is it increasingly difficult to escape. And as pharmaceutical companies increasingly profit from curing those labeled in these ways, so are these companies contributing to the disempowering of the individual.

Let us consider for just a moment the specific ramifications of this individualist focus in psychotherapy as it relates to the therapeutic relationship. While it is the case

that there are many modes of psychotherapy where emphasis is placed on moving beyond personal or psychological distress, the profession requires first and foremost that a diagnosis be identified before moving toward problem resolution or treatment. In fact, because psychotherapy is tightly linked to the medical profession, the overwhelming belief is that psychotherapy, in order to proceed, *demand*s diagnosis. How could a therapist know how to treat a client if that therapist was operating without a clear idea of what the client's problem was in the first place? To treat a problem then requires diagnosis. Two issues are relevant here: (1) the issue of diagnosis as it relates to individualism and therefore the implication that deficiency resides within the person requiring individual diagnosis and (2) the issue of diagnosis as a necessary conversation (particularly in psychotherapy) that revolves around identification of problems, the causes of the problems, and the resolution of problems. These issues are not necessarily separable and have significant implications for the therapeutic relationship. Yet let me expand just a bit on each to set the context for a constructionist alternative.

Diagnosis of individuals. Central here is the observation that diagnosis in psychotherapy means diagnosis of an individual. If one's identity is located within the person, as individualism tells us, then all that is problematic must emanate from the internal mind or psyche of that person. Thus the diagnosis must be of the person, of the individual. There are certainly situations where such diagnosis can be useful. I think of the varying responses different people might have to the diagnosis of chronic depression. For some, learning from the "expert" (i.e., psychotherapist) that they are suffering from

chronic depression can be helpful. The diagnosis gives them the sense that now that the problem has been identified, a treatment program can begin. There is hope in sight. Yet we must not forget all those others for whom the diagnosis of chronic depression (or any other diagnosis) initiates a tailspin into further malaise. Armed with the diagnosis, these people lose hope by virtue of being identified as flawed, inferior, unhealthy, and anything but “normal.”

Diagnosis requires problem talk. Psychotherapy, diagnosis and problems are terms that naturally go together. We seek psychotherapy when we feel uneasy, unsettled, or disturbed. When things are not going well in our lives, psychotherapy is one of the central places we turn for help. Given this assumption, it is difficult to imagine the utility of a psychotherapeutic conversation where the central topic of discussion is not problem oriented.²

However, to view therapy as social construction is to open the therapeutic conversation to a broader range of issues. Specifically, it is to entertain the question: What can *we* accomplish (i.e., create) in our conversation together? There are multiple

² There are, however, several forms of therapy that attempt to move beyond problem discussion. Solution focused therapy (deShazer, 1994; O’Hanlon and Weiner–Davis, 1988) and the narrative therapy of White and Epston (1990) are popular illustrations of therapeutic models where emphasis is placed on the imagination of alternative constructions of the situation at hand as well as of the future. These methods shift the conversation away from problems and diagnosis replacing the focus of therapy on conversations of possibilities. Yet, talking about solutions to a large degree implies problems and constructing new narratives in therapy suggests that the client’s story is defective. While these models are seen as significant moves in the development of alternatives to individualist diagnostic models of therapy, to the constructionist, they do not go far enough.

ways in which personal and relational transformation can occur. Diagnosis and problem talk might be generative as might conversation focused on strengths, values, and future possibilities. When we view therapy as social construction, we are not particularly interested in pre-determining what sort of conversation will produce transformation. We are more concerned with adopting what I refer to as a relationally engaged stance with clients. Within such a stance, we can accomplish generative therapeutic conversations.

My claim is not that diagnosis is bad or wrong. Rather, my point is that when we explore psychotherapy as social construction, our attention to the therapeutic relationship is distinct. It is focused on how therapist and client, together, might expand the range of resources for action. This *might* require the therapist and client construct a relationship wherein the therapist becomes the expert or authority, and, in particular, the expert who is capable of providing a diagnosis and treatment plan. Yet, it also might require the therapist and client to construct a discursive domain where the interaction departs from the cultural expectations of psychotherapeutic conversations (i.e., therapist as diagnostic expert). Here, the therapist and client work together to create a more collaborative conversational space where the therapist's role as expert is not central. With no clear a priori notion of who the therapist *should* be (expert, authority, or equal conversational partner), the question arises concerning the role of the therapist. Can we *know* who we should be in the therapeutic relationship *before* we even engage in it?

At this point, we must consider the **constructionist emphasis on collaboration, “not knowing”** (Anderson, 1997) and the **communal construction of meaning**. Such emphases seem,

from one extreme view, to discredit the therapist as professional. Specifically, they call into question traditional expectations about psychotherapy including the expectation that the therapist, by virtue of his or her professional expertise and authority is “right,” that the therapist *should* focus the therapeutic conversation on the past, that the therapist *should* provide the client with new resources for action, that the therapist *should* focus on the problems clients bring to therapy.

Therapy as Social Construction: Relationally Engaged Practice

If constructionism lacks specification of a particular therapeutic technique, what is it, precisely, that constructionism offers the field of psychotherapy? Perhaps the most useful way to talk about the relationship between constructionism and therapy is to recognize that there are no constructionist therapies *per se*. Rather, constructionism, as a philosophical stance, positions us to view therapeutic process as a *conversation* or *dialogue*. This is distinguishable from cognitive, behavioral, psycho-dynamic, and psychoanalytical models that prescribe particular topics, issues, or even styles for the therapeutic conversation. However, this point has not been well articulated to date in the constructionist literature.

Recall that, for the constructionist, language is the focus of our concern. It is in language that we create the worlds in which we live. Thus, it should come as no surprise that in therapy, we are focused on the discourse of all participants and how particular discursive moves constrain or potentiate different forms of action and, consequently, different realities. This is a liberating stance because when we become curious, as opposed to judgmental, about how people engage with each other, we open ourselves to the consideration of alternatives. This particular feature is often associated with the constructionist focus on *uncertainty*. Attention to language (which, to

the constructionist includes all embodied activities) positions us in a reflexive relationship to our own actions as well as to the actions of others. We are poised and prepared to ask, “What other ways might I invite this client into creating a story of transformation?” “How is she inviting me into legitimating/transforming/challenging (etc.) her story?” “What other voices might I use now?” “What other voices might he use?” and so on.

To maintain a focus on *therapy as conversation*, I find it useful to be attentive to how we might focus on our activity with others. Constructionism is not a better stance to take in the psychotherapeutic context. It is not a technique. Rather, constructionism is an orientation to therapeutic process that privileges what is happening in the conversation. The focus is on dialogue, not on people, situations, or problems. This is a significant difference because it positions the therapist in an open manner to *any* method of therapy. Behavioral, cognitive, psychoanalytic, narrative, solution focused, and so forth *all* become *potentially* viable and generative ways of relationally engaging with clients.

Theories and techniques as discursive options

Any particular discourse (or in this case, any particular theory or model) becomes a potential resource for transformation rather than a tool that will *bring about* (read: cause) transformation. Social construction, as a therapeutic stance, tunes us into the interactive moment where therapeutic change might be possible. The challenge, of course, is that there are no specific techniques, nor are there any desires, to determine which ways of talking are therapeutic and which are not. The question of what is therapeutic remains open and indeterminant, just like conversation. When therapy is understood as a *conversational process*, we can never be certain where it will go. I can never fully predict another’s next move and consequently, the potential

for moving in new directions, generating new conclusions and possibilities (and constraints) is ever present. What we can do, however, is remain attentive to what conversational resources we select and which ones might serve as useful alternatives. It is important at this point to emphasize that (1) we make no attempt in constructionist practice to act in a particular manner – beyond remaining responsive to the interactive moment, (2) we become relationally engaged by focusing attention on the conversational processes of all those involved (rather than on individuals, objects, problems, or specific strategies), and (3) we can not “know” what forms of relational engagement (what specific actions) will contribute to therapeutic change.

This last point, in particular, can be very unsettling for many of us (and our clients, as well as for review boards). But remember, therapy is conversation. We can never anticipate precisely the outcome. Is this a problem? I don’t think so. If we remain attentive to the process of relating, itself, we will be attentive simultaneously to the additional voices we all carry (friends, colleagues, family, culture, and so forth). In so doing, we are more likely, I believe, to engage in inquiry that encourages multiple stories, multiple possibilities, and thus, the potential for therapeutic transformation.

Implications for the Therapeutic Relationship

Selecting a theory or technique as a *practical option* (as opposed to a truthful option) for action enhances our ability to be relationally engaged with clients. We become sensitive to their stories and our own in ways that allow us to be responsive and relationally responsible (McNamee and Gergen, 1999). There are many ways in which we might pragmatically achieve such a responsivity. I would like to identify three conversational themes that could usefully focus our attention on relational engagement rather than on proper methods. Surely, many more

themes can be added to the list. These three simply serve as useful in achieving relationally engaged therapeutic practice. Let's take a brief look at these themes and consider how each might be useful in approaching *therapeutic process as a conversational activity and thus, constructing the potential for a range of therapeutic relationships..*

Using familiar resources in unfamiliar places. Tom Andersen talks about introducing not too much change and not too little change but just enough change. He echoes Bateson's well-known phrase, "the difference that makes a difference" (1972, p. 272). Here, I am suggesting a variation on this common theme. We all carry with us many voices, many differing opinions, views and attitudes - even on the same subject. These voices represent the accumulation of our relationships (actual, imagined, and virtual). In effect, we carry the residues of many others with us; "we contain multitudes." Yet, most of our actions, along with the positions we adopt in conversations, are one dimensional. They represent only a small segment of all that we might do and say. The challenge is to draw on these other voices, these conversational resources that are familiar in one set of relationships and situations but not in another. In so doing, we achieve *just enough difference* as Tom Andersen proposes.

Using familiar resources in contexts where we do not generally use them invites us into new forms of relational engagement with others. If we think of all our activities as invitations into different relational constructions, then we can focus on how utilizing particular resources invites certain responses/constructions in specific relationships and how it invites different responses and different constructions in others. Let me elaborate by focusing attention, for the moment, on the issue of professional identity.

We inherent from modernist discourse the expectation (assumption) that there is a proper

way to be a professional therapist. We often see it in trainees when they begin seeing clients. They are more likely to talk as they believe a therapist should talk thereby ignoring those conversational resources that are familiar. The familiar becomes alienated and what has previously been alien (e.g., the identity of therapist) is miraculously supposed to be instantly familiar! This reminds me of my own clinical training. As a researcher of therapeutic process, I spent years interviewing families, couples, and individuals about their therapy. After many years as a researcher, I decided to take the plunge and train to become a therapist. When I finally initiated my training, I found myself almost speechless with clients. Not only did I have a hard time thinking of questions to ask (regardless of how much pre-session time had been spent generating hypotheses and questions), but I was constantly monitoring myself for *how* I asked questions. I wondered endlessly about whether or not everything I did or said was “right,” given my new role as therapist.

One day, while sitting with a client, my supervisors called me out of the room. They asked one very simple question: Are you comfortable and confident when you interview people for your research? My response was affirmative. They said, “Then go back in there and act like a researcher.” This directive was so liberating for me that I forgot my fear of *acting like a therapist* and simply engaged in conversation with the client. What I realized in this moment was how our attempts to be good professionals actually can prohibit our ability to be relationally responsive (as professionals) in our conversations with clients. I also realized the benefit of using a familiar repertoire in a context where I wouldn’t expect it would serve as an appropriate resource. If we can encourage ourselves (and others) to draw broadly on the conversational resources that are already familiar, perhaps we can act in ways that are *just different enough* to

invite others into something other than the same old unwanted pattern.

This idea, I believe, is distinct from what we expect of ourselves as therapists. We expect (and our clients expect us) to converse within a limited and pre-legitimized range of topics and terms. That range is dictated by the theory within which we practice. Thus, for the behavioral therapist all conversation is drawn from the realm of learned patterns of behavior and associated concepts. The novelty in using theories or models as forms of discourse is that doing so allows us to engage in a responsive way with our clients. We are free to abandon the need to persuade clients that our knowledge of their problems is not only authoritative but correct. Instead, we can engage *with* our clients in collaboratively constructing (even if our part of the collaboration is from the *achieved* stance of authority) alternative ways to talk and act about and within their life circumstances.

Focus on the future. If you examine the field of psychotherapy, you will note that a good deal of therapy talk hovers on the past. Therapists and clients alike explore the history and evolution of the problems that clients bring to therapy. When did the problem begin? How long has it been a difficulty? How have you come to understand (make sense of) the problem? What do you think causes the problem? What do others say about it (and you)? What have you done to try to solve this problem? The questions that therapists ask direct the therapeutic conversation toward the past, as do the expectation that many clients bring to therapy. Most cultural presentations of therapy (consider any Woody Allen film) portray client and therapist locked in a conversation about the past (childhood, adolescents, etc.).

With such an emphasis on these past-oriented questions, there is little room for imagining the future. The potential to sediment the past, to reify the story, and thereby make it static and

immutable is tremendous. Probably more important, is the logic inherent in the therapeutic focus on the past. By focusing on what has already transpired, we unwittingly give credibility to causal models that are the hallmark of modernist science. We privilege the logic that claims that what went before causes what follows.

As a constructionist, I don't necessarily want to argue for a disconnection between past, present and future. I simply want to raise the issue of narration. The past is always a story. And we all know that there are many ways to tell a story. Not only do we harbor many voices, each with a different set of possible narrations, but others involved in the same "history" will very likely narrate it differently. Thus, the causality of past to present (and implied future) will take different turns, highlight different features, and pathologize varied aspects depending on which story is privileged.

One reason that future-oriented discourse enhances relational engagement is because we all understand that we do not yet *know* the future. We have not embodied it yet. And thus, to the extent that we engage *with others* (our clients in this situation) in conversation about the future, we underscore the relational construction of our worlds. We fabricate together what we might live into.

This is not to suggest that talk of the past is wrong or emblematic of "bad" therapy. Instead of privileging a particular way to talk and/or particular themes or topics for therapy, constructionism emphasizes the collaborative, situated creation of possibilities and *one way* to achieve this is with future-oriented discourse.

Entertaining ideal scenarios. Related to a focus on the future is conversation centered on the ideal. Often we associate ideal talk with talk of the future. It is, after all, fantasy-like in

that it is usually unknown – like the future. However, we can invite our clients to talk about how things would be for them in the present if the past had been ideal. Ideal talk can enhance relational engagement by honoring a painful or sedimented client story. Asking how things ideally would have been, should be, or might be does not disregard how they are presently narrated by a client and thus do not further pathologize the client. This attentiveness to the story of the client fosters a relational sensitivity. Here, however, I am not discussing relational sensitivity as a strategic stance of the therapist but rather as an embodiment of the constructionist focus on language and *conversational process*. The suggestion here is simply that the language of the ideal can serve as a bridge between stories of despair and stories of hope.

The Provocative Issue on the Table for Psychotherapy

I have tried to articulate that therapy as social construction can not be coherently equated with an image of therapists and clients to creating meaning *as they choose*. Constructionism hinges on the very important notion of ***relational engagement***. We are all accountable not only to those with whom we engage in the therapeutic context, but we are also ***relationally responsible*** to a myriad of others within our professional, personal, cultural, and global communities.³ Yet, talking about therapy as conversation raises interesting questions about the therapeutic relationship.

In sum, let me review what I see as the specific issues constructionism raises for the

³Of course, this raises a significant issue which deserves much more discussion. How can any person or set of relationships be simultaneously responsible (as in relationally responsible) to competing and divergent communities? If a therapist is relationally responsible to his or her client, does this mean he or she is also relationally responsible to a professional oversight board? What happens when such relational responsibilities are incommensurate? In the age of managed care, this issue is clearly negotiated on the side of the insurance companies often at the expense (psychological, physical, relational, and financial) of the client.

therapeutic relationship. First, social construction, with its relational focus, presents a challenge to traditional notions of expert knowledge and professional neutrality. It is not the case that constructionists do not recognize expertise or authority. What constructionists call into question is the *unquestioned presumption* that the therapist *should* be the authority (and that it is only in the therapist's position as authority or expert that psychotherapeutic success can be accomplished). I suggest that the task at hand is one of coordination between therapist and client. That coordination might include problem talk, diagnosis, and an authoritative stance taken by the therapist. It is also likely that it might require the therapist to adopt the stance of an equal conversational partner who does not know with certainty how to understand or make sense of the client's problem. Furthermore, it might involve conversation about possibilities, potentials, ideals, and so forth. The point is, from a constructionist stance, we can not know ahead of time what will be the most generative therapeutic relationship for any given client.

Second, constructionism raises the question of what becomes the focus of therapeutic conversation. Traditional therapy focuses on the past to understand the present. Therapy informed by a constructionist sensibility places focus on the *interactive moment* – the past, present, and future as they are narrated in the present. To that end, rather than attempt to provide clients with new resources for action, therapy attempts to help clients utilize the conversational resources they *already have*, in new and unusual conversational arenas. Additionally the therapeutic conversation might focus on the future, as well as on the discourse of the ideal.

Finally, there is a difference between ignoring the past (as it is narrated) and valuing participants' understandings of the past as coherent, rational, and legitimate. With constructionists arguing for attention to the interactive moment, a good deal of confusion has

emerged about *how* a therapist can honor the client's desire or lack of desire to focus on the past. ***Talk about the past always takes place in the present.*** The "rationale" for talking about the past is not, for the constructionist, to dig into the causes of the client's problem. The past need only be discussed inasmuch as the client finds relevance in telling his or her history. And, when this does, in fact, have relevance for a client, the therapist who sees psychotherapy as a process of social construction can explore how to move on from a value of the past (respect for the past) to a generative future.

What does this imply for the psychotherapist?

The uncertainty that is associated with constructionism is one that invites multiplicity and thereby invites therapists and clients alike to question their assumptions and explore alternative resources for personal, relational, and social transformation. We could call this *generative uncertainty*. Generative uncertainty positions therapist and client in a therapeutic relationship that is responsive to the interactive moment. The therapist is now a conversational partner and as such is free to move within the relationship in ways that enhance both therapist's and client's abilities to draw on a wide range of conversational resources. The therapist is not burdened with being "right" but with being *present* and *responsive*. The therapist and client become accountable to each other. Yet, accountability, presence, and responsivity to each other is not enough. Our conversations in the psychotherapeutic context might be more usefully centered on community transformation. How might we, as psychotherapists, invite clients into the sorts of relationships that effectively transform our ways of living communally together. To that end, constructionism would suggest that our understanding of the term ***therapeutic relationship*** expand well beyond the therapist-client relationship.

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