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Collaborative Practice: A Way of Being "With"

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ABSTRACT *We live and practice in a rapidly changing world in which people demand democracy, their human rights and social justice, and want to have a voice in concerns that affect their lives. Such changes and demands require practitioners to step back and reflect on their practices and find ways to keep our practices in sync with these. This article presents collaborative practice, a dialogic conversational therapy, as a response. It discusses the assumptions on which the practice is based and the implications for the practitioner's stance. Two examples of clients' experiences and descriptions of a consultation session illustrate the transformational nature of such conversations. Copyright © 2012 John Wiley & Sons, Ltd.*

Key words: collaborative relationships; psychotherapy dialogue as transformative; conversational therapy; mutual inquiry; not-knowing; relational transformation; philosophical stance

INTRODUCTION

How can our practices have relevance for people's everyday lives in our fast-changing world, what is this relevance, and who determines it? For me, this is a persistent, seemingly simple yet complex, multifaceted question. In this article I present and discuss a collaborative approach to practice as one response to this question – and I use "practice" and "practitioner" as inclusive terms whether I am practicing as a therapist, consultant, trainer or researcher. Collaborative practice breaks with those psychotherapy traditions based on the therapist–client as representing an expert–non-expert system, and/or as a technological, pre-structured, and interventive process based on and in deficit language. Collaborative therapy offers a different framework and attitude that calls for reimagining how we think about the people we work with, and our roles as practitioners. First, I set the stage for presenting an overview of collaborative practice by briefly presenting the framework of perspective-orienting assumptions on which it is based. I then present the practitioner's position as reflecting the action-orienting sensitivities that flow from the assumptions: the practitioner's philosophical stance or way of being "with". I follow this with two examples of client transformations and use their words to express their thoughts and actions after the consultation sessions.

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INFLUENCES

Historically, the collaborative approach has favored the recognition and use of local or insider knowledge – the "know how" that a client has about his or her life and needs. More recently, this emphasis has been further influenced by the liquid, shrinking and ever-changing world in which we live: a world characterized by social, cultural, political and economic upheavals and transformations, along with the effects of a move toward the decentralization of information, knowledge and expertise. This influence is amplified by the international spotlight shining on democracy, social justice, human rights, the importance of the people's voice and the need for collaboration as evidenced, for instance, by indigenous people's protests for their lost rights.

In my travels, I have talked with clients around the world, and they increasingly indicate they want input into what affects their lives. They have lost faith in rigid institutions and are frustrated with being treated as numbers and categories that ignore their humanity or, worse, violate it. Clients demand systems and services that are more flexible and respectful; in other words, they demand that we question our professional practices. This, in turn, tests our readiness to break from those psychotherapy traditions which are not in synchrony with our contemporary world, and to create alternative therapy systems and processes that are less hierarchical and driven by the expert within. One testament to these demands is the focus of this Congress of the World Council for Psychotherapy on the theme of "World Dreaming", including the impact of interpersonal trauma on individuals, communities and cultures, and its reverberation across generations in terms of the devastating effects on identity and well-being, and its call for responses that recognize the critical importance of new ways of being together.

Becoming a collaborative practitioner has, for me, been an evolutionary journey over the years, one continually influenced by the reflexive nature of theory and practice (Anderson, 1997a, 2007a,b; Anderson & Goolishian, 1988, 1992; Anderson, Goolishian, Pulliam, & Winderman, 1986; MacGregror et al., 1964). Because a large percentage of my practice has always included what are commonly called "treatment failures", I wondered: what do clients distinguish as the special nature of therapy and therapists that made a difference? In other words, how could therapy become more relevant and effective? For several years this determined curiosity led me to interview clients about their experiences of successful and unsuccessful therapy (Anderson, 1997b). What I learned from these clients significantly influenced the development of my collaborative practice.

Collaborative practitioners share common ground with a growing international community of practitioners and clinical scholars across disciplines whose work is based on assumptions drawn largely from postmodern and hermeneutic philosophy and dialogue and social construction theories. In the psychotherapy disciplines this movement, which initially largely developed within the family therapy field, represents a turn away from therapies based in concepts such as language and words as representative and descriptive of the world, knowledge as an individual construct, objectivity and, as Hoffman (2007, p. 66) put it: "problems as a within-person phenomena" – and a turn towards therapy that is based on understanding language as a social process of meaning-making in which "meaning is in the expression, not under or behind it" (Andersen, 2007, p. 89), and life challenges, whatever the perceived degree, as relational and dialogic. This grouping of therapies is variously referred to as: conversational, dialogical, discursive, narrative, open-dialogue, postmodern, social constructinist

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and "withness" (Andersen, 1987, 1991; Anderson, 1997b; Anderson & Gehart, 2007; Anderson & Goolishian, 1988, 1992; Anderson & Jensen, 2007; Anderson et al., 1986; Hoffman, 2002, 2007; Katz & Shotter, 1996; Malinen, Cooper, & Thomas, 2012; McDaniel, 1995; McNamee & Gergen, 1992; Penn & Frankfurt, 1994; Riikonen & Smith, 1997; Seikkula & Olson, 2003; Seikkula et al., 1995; Sermijn, Devlieger, & Loots, 2008; Strong & Paré, 2004; White & Epston, 1990).

COLLABORATIVE PRACTICE AS POLITICAL

The reader may wonder how collaborative practice is "political" and, importantly, what is its relevant to this journal's focus, as described in its mission statement, on "the application to political problematics of thinking that originates in the field of psychotherapy" (*Psychotherapy and Poltics International*, 2012). Although there are agreed definitions of the "political", each person has their unique view of politics and the political. My understanding is close to the classic Greek sense of participatory decision-making in relation to power and authority: people as citizens making decisions together and having the right and opportunity to influence their own lives. In this sense everything is political, including the issue of whether, when and how people can participate through dialogue to arrive at outcomes collectively or, I would say, "collaboratively".

Challenging psychotherapy traditions and the authority that comes with them is political. The politics of collaborative practice rest partly in this challenge. This includes a call for shifts in our thinking including: critically analyzing dominant discourses, e.g., the social, the cultural, and the psychotherapeutic, and the universal truths they purport; and shifting from an individual discourse to a relational one that privileges local knowledge. Collaborative practice also calls for shifts in our actions including: setting aside taking on the role of helper; moving from "aboutness" thinking to "withness" thinking and being; maintaining coherence in our ways of being in our professional and personal worlds; and being visible as a person; all of which, in one way or another, contribute to the creation of an alternative view of language and meaning, in which one human being is in relationship with another human being.

THREE PERSPECTIVE-ORIENTING ASSUMPTIONS AND THEIR INHERENT CHALLENGES

Along with what I learned from clients, my collaborative approach was inspired by a growing and shifting collection of perspective-orienting assumptions that thread through postmodern and hermeneutic philosophy and social construction and dialogue theories as exhibited in the writings of critical thinkers such as Wittgenstein (1953); Foucault (1972); Gadamer (1975); Derrida (1978, 2000); Bateson (1979); Lyotard (1984); Bakhtin (1986), Vygotsky (1986) and Deleuze and Guitarri (1987), along with academic scholars such as Shotter (1984, 1993, 2010); Gergen (1985, 1999), and Sampson (2008). Concepts of knowledge, language and dialogue as relational, participatory, interpretive and inherently transforming provided a language for understanding my own experiences of practice and, along with what I learned from clients about their experiences of therapy, culminated in a challenge to what I had inherited about psychotherapy and other practice traditions, and stimulated an opportunity for developing an alternative perspective. Here, I discuss three perspective-orienting assumptions and their inherent challenges for the way practitioners think and act. "Perspective-orienting"

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refers to a viewpoint and attitude from which we attend, approach, relate and respond to our world, others and ourselves in a spontaneous manner (Shotter, 2008) rather than from theoretical assumptions that inform pre-knowing and planned method, technique, and strategy (see Anderson, 1997a, 2007, for an expanded body of assumptions).

Maintain skepticism

It is important to maintain a critical and questioning attitude about knowledge as fundamental and definitive. This includes knowledge of inherited and established dominant discourses, meta-narratives and universal truths or rules, and the authority that comes with this inheritance. We are born, live and are educated within knowledge systems and traditions that we usually take for granted. Unwittingly, we often buy into and reproduce institutionalized knowledge that can lead to practices that are out of rhythm with our contemporary societies and possibly alien to humanity as well, regardless of the context and culture. I do not suggest that we abandon our inherited knowledge or discourses (e.g., psychological or cultural), nor do I suggest that postmodern or social construction, for instance, are meta-knowledge narratives. Any and all knowledge can be useful.

The challenge is to break away from a non-questioning of our inherited psychotherapy traditions including the pervasive narrowness and insularity of disciplinary thinking. The call is to be a reflective practitioner: to question any discourse's claim to truth. This would include the philosophical and theoretical discourses on which collaborative practice itself is based.

Avoid generalization

Dominant discourses, meta-narratives and universal truths can be generalized and applied across peoples, cultures, situations or problems. Thinking in terms of such ahead-of-time knowledge, e.g., theoretical scripts, and predetermined rules, can create categories, types and classes of people, problems and solutions that can inhibit our ability to learn about the uniqueness of each person or group of people and their circumstances. In other words, familiarity can risk depersonalizing the person; it can tempt us to fill in the gaps and proceed, based on our assumptions rather than learning from the person we are talking with, and it can limit both our and their possibilities.

The challenge is to beware (be aware) of the seductiveness of generalizing knowledge and the possibility-limiting nature of seeing and finding what you are looking for, and the risks associated with each. Instead, we must learn about the distinctiveness of each person and their life directly from them and to see the familiar, or what we think we might pre-know in an unfamiliar or fresh way. In so doing, we maximize the possibility of co-creating solutions that are unique and fitting to them and their circumstances.

Privilege local knowledge

Local knowledge, such as the expertise, truths, values, habits, narratives and wisdom that is created within a community of ordinary people, e.g., a family, school classroom or business board room, who have first-hand knowledge of themselves and their situation is important. Related to the theme of the World Congress, this would include indigenous or ancestral knowledge.

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Local knowledge, formulated within a community to address its self-defined needs can, therefore, be more relevant, pragmatic and sustainable for that community. Local knowledge, of course, always develops against the background of dominant discourses, meta-narratives, and universal truths and is influenced by these conditions. It is not suggested that it is or can be otherwise or that this background should be or can be avoided, but the challenge is to be ever mindful of the value of local knowledge, "the need for local understanding, actions and solutions" as the World Congress for Psychotherapy (2011), put it, is critical to being able to hear what the other judges important for you to hear, and to suspend pre-knowing which can interfere with hearing. I distinguish between hearing and listening which I discuss below (p. 6). This contributes to outcomes that are particularly fitting to the person and their situation and therefore to their sustainability.

Heidegger suggests that:

> being-in-the-world is a constant search for meanings – meanings about how we can understand ourselves and our surroundings. What we thereby come to understand will influence how we relate to the surroundings as well as to those persons who are there . . . What we come to understand is related to what we see and hear. (cited by Andersen, 1996, 119)

PRACTICAL IMPLICATIONS OF PERSPECTIVE-ORIENTING ASSUMPTIONS

These assumptions collectively encourage us to reflect critically on our current thinking boxes such as categories and constructs and to be open to changing the way we see and hear, and thus our way of being. They encourage us to have a different attitude about the people we work with, our relationship with them and what we hope to accomplish and how we accomplish it. They encourage us to view each person and their circumstances as unique. If we can change our way of understanding and become aware of the limiting nature of our pre-understandings, we can open up the possibility of seeing and hearing the seemingly familiar in an unfamiliar or novel way, which in turn may then influence our understandings and change our pre-understandings. Heidegger calls this contextual nature of knowledge the hermeneutic circle: the reflexive nature of the interaction of our pre-understanding and the process of understanding through which new understanding can emerge and our pre-understanding can also change in the process (see Wachthauser, 1986). In other words, the part and the whole are always understood in relation to each other, and new understanding can be an outgrowth of this interpretive process.

I am often asked "What are the implications for therapy?" and "What are the techniques, the steps of therapy?" My somewhat provocative response is that the notion of techniques and steps is not part of a collaborative approach. Collaborative practice breaks with the traditions of manualistic, scripted or formulaic therapy. Instead, it is informed by what I call a philosophical stance or a way of being "with". My use of the term "a way of being "with"" does not draw on Rogers (1980) concept of a way of being (for further discussion of the similarities and differences between Rogers' humanistic perspective and collaborative practice, see Anderson, 2001). This therapist way of being "with" invites and sustains particular kinds of relationships and conversations: collaborative and dialogic ones. Collaborative relationship and dialogic conversation refer to the metaphorical space (dialogical space not literal space) and the polyphonic process (a plurality, multiplicity and diversity of

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voices) in which transformation is generated. In other words, transformation occurs in the dynamics of the relationship and the meaning-making process of expression, i.e., the conversation.

The essence of a collaborative relationship entails sensitivity to and a willingness to constantly examine the way in which we orient ourselves to be, act, and respond "with" another person. It refers to a certain kind of connection in which what the other feels what they have to offer is appreciated, valued and not judged. Consequently, they feel invited to a joint engagement that I call a shared or mutual inquiry, which I elaborate below. It is a relationship in which a therapist invites and encourages a client as well as herself or himself to have a sense of participation, belonging, ownership, accountability and responsibility.

Dialogue, according to Bakhtin (1986), is a form of communication in which participants engage "with" each other (out loud) and "with" themselves (silently) in a search for meaning and understanding. This includes any way we try to communicate, articulate and express ourselves, including words, signs, symbols, gestures, etc. In practice, dialogue involves a shared or mutual inquiry: jointly responding, e.g., commenting, examining, questioning, wondering, reflecting, nodding, gazing, as we talk about the issues at hand. Dialogue requires the capacity to try to understand the other person from their perspective, not ours. Dialogic understanding is not a search for facts or details but an orientation and a process that always assumes the presence of misunderstanding. It is an (inter)active way of being with that requires participation through responding in order to connect with and learn about the other from them, rather than to pre-know and pre-understand them and their words from a predisposition such as a theory. In this sense, dialogue is neither directive nor passive.

Trying to understand involves the reflexive, intricately woven process of listening, speaking and hearing: each is critical to the other. The therapist not only listens attentively and carefully but responds, speaks to check out if what is heard is what the client hopes the therapist heard. The therapist, as a continual learner, responds with genuinely curiosity, by asking questions to learn more about what is said, not what the therapist thinks should have been said. In listening, speaking and hearing, the therapist is engaging with the whole of the story; this is different from listening and speaking to gather details and facts.

Collaboration and dialogue go hand in hand; each is critical to the other. In my experience, when people inhabit a metaphorical space and are engaged in a polyphonic process for collaborative relationships and dialogic conversations, imagination and creativity are invited as they begin to talk with and hear themselves, each other and others, in new ways that permit the construction of something that has not existed before. The newness that develops can express itself in an infinite variety of forms, such as in understanding and action and in enhanced self-agency and freeing self-identities (Goolishian & Anderson, 2002).

Within the culture of psychotherapy and within our broader cultures in general, the orienting assumptions offer a discursive option that fosters new understandings and practices. It is a political option that calls into question many of our grand narratives that we take as fact and help us avoid imprisonment by our traditions and the rules we inherit with them. Along with the philosophical stance that flows from them, we are able to foster new understandings and practices as our attention is drawn to the sometimes unwittingly oppressive nature of expert truth claims such as how another person should live a life. The voice and know-how of the ordinary person becomes as relevant and important as that of the culturally designated professional, thus having

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the potential to dissolve relationship dualisms and flatten institutional hierarchies. Communities of practice develop that are not immersed in vocabularies such as defect and deficit and policing languages such as blame and judgment. For me, this option has promise for influencing not only our therapies but our social and political practices.

We are, however, still left with the question, "How can practitioners invite, facilitate and sustain the condition for collaboration and dialogue?" In response to this, I turn to a discussion of the philosophical, and political, stance that underpins collaborative practice.

THE PHILOSOPHICAL STANCE

The philosophical stance is the art and spirit of collaborative practice. Inspired by Shotter (1993), I use the phrase "philosophical stance" to highlight a sensitivity toward a particular kind of attitude from which a therapist's words and actions emerge in response to the other, and to highlight a move away from the notion of "guiding". The idea that therapy is an art is influenced by Hoffman's (2007) view that the spontaneous way a therapist participates in the kinds of therapy conversations that I refer to is "more like the way a creative artist operates than a trained professional" (p. 77) and by Andersen's (2007) emphasis on therapy as human art, i.e., "the art to participate in the bonds [of exchanges] with others" (p. 82). The philosophical stance of collaborative therapy is a way of being "with" that involves a posture, an attitude and a tone that communicates to another the special importance that they hold for me, that they are a unique human being and not a category of people, and that they are recognized, appreciated and have something worthy of saying and hearing. It reflects a manner of engaging with the other that includes thinking with, talking with, acting with and responding with them, instead of to, for or about them. The significant word here is *with*: a "withness" process of orienting and re-orienting oneself to the other person as a participant within the therapy system, rather than as an observer interpreting it from outside of it. Withness derives from the work of Bakhtin (1986) and is a concept which both Hoffman (2007) and Shotter (2010, 2012) write about. Withness refers to a dialogical activity in which we are spontaneously and relationally responsive to the other, while aboutness refers to a monological activity in which we only think, see and respond in terms of what is already familiar to us (Shotter, 2010). The philosophical stance and its withness relationships and conversations invite and encourage a therapy system, process and relationship that is less hierarchical and less dualistic. People participate on a more equitable basis and therapy becomes more participatory and mutual.

The philosophical stance I am advocating becomes an expression of a value, a belief, and a politics that does not separate the professional from the personal. Moreover, being a person, and maintaining coherence across contexts and relationships, is about being congruent as a person, not performing the role of a therapist. Doing so risks being like an actor performing a role based on a script. An actor sticks to a script, setting aside other roles. As a therapist, performing a role can interfere with the spontaneity of being present with the other, being responsive to the interactive moment and doing what a unique occasion calls for.

SEVEN INTERCONNECTED FEATURES OF THE PHILOSOPHICAL STANCE

The beliefs and attitudes – the way of being "with" – that flow from the philosophical assumptions discussed earlier become action-orienting sensitivities that influence authentic,

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spontaneous and natural actions, not techniques or pre-structured steps. I ask the reader to distinguish how, combined and separately, each has a political implication regarding our traditions.

Mutual inquiry

Practitioner and client form a conversational partnership characterized by a joint activity of shared or mutual inquiry. It is an "in there together", "doing with" process in which two or more people put their heads together to puzzle over and address something. The practitioner invites the other person, or persons, into this mutual inquiry by taking a curious, learning position. The therapist's curiosity becomes contagious as the client becomes interested in their circumstances in ways not before possible – either with themselves or others.

My responses, whether questions, comments, gestures, etc., are informed by and come from inside the conversation itself: they relate to what the person has just said or done. They are not informed by my "truths" about them such as what they should be talking about or should be doing – truths which would be derived, for instance, from theoretical maps, clinical experience or personal values. My responses are my way of participating in the conversation and are offered from a continual learning position to ensure that I understand the other as best I can. My aim is to encourage the back-and-forth process that I call mutual inquiry, in which a client engages in a new curiosity about the situation for which therapy was sought. Though this engagement begins with the therapist, it extends to a client's talk with self and with others. Through the process of mutual inquiry the client begins to develop meanings for themselves and the people and events in their lives that permit expanded or new agency. The newness comes from within the inherently transforming dialogic process.

Through this joint activity, the relationship and conversation begin to determine the process or method of inquiry. The method does not define the relationship and the conversation but just the opposite, that is, client and practitioner create from within the moment-to-moment unfolding of the present relationship and conversation, not from outside it or ahead of time. The practitioner does not control the direction of the conversation or story-telling but participates in it. Together, client and practitioner shape the story-telling, always a re-telling that is at the same time a new-telling that yields a richness of novel, freshly seen possibilities and previously unimagined futures.

It is important for the practitioner to make ample room for and to facilitate listening and speaking. In my experience, in the dialogic process that I am referring to, as one member of a family speaks and the others listen, all parties begin to experience a difference in the story tellings and re-tellings. When a speaker has the room to express himself or herself fully without interruption, and the other(s) equally have a full capacity for listening, all begin to have a different experience of each other and what is said and heard. When you are able to listen fully without, for instance, sitting on the edge of your chair preparing a corrective response, you have the opportunity to begin to hear and understand things in other ways.

Relational expertise or the client is the expert

Both client and practitioner bring expertise to the encounter: the client is an expert on themselves and their world; the practitioner is an expert on creating a space and process for collaborative relationships and dialogic conversations (Anderson & Goolishian, 1992). The focus

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on the expertise of the client does not deny or negate the expertise of the practitioner: it calls attention to the client's wealth of "know-how" on his or her life and cautions us not to value, privilege and revere the practitioner as a better knower than the client. The therapist's expertise is present but not in a hierarchical or instructive fashion.

I do not suggest that a practitioner lacks or pretends a lack of expertise. Therapists, of course, have expertise but, from a collaborative perspective, it is a different kind of expertise: it is expertise in inviting a person into and maintaining a space and process for collaborative relationships and dialogic conversations. Together, client and therapist create a new expertise or knowledge.

Not knowing

Not knowing refers to two things: one, how a practitioner thinks about the construction of knowledge; and two, the intent and manner with which knowledge is introduced into the consultation (Anderson, 2005). It is a humble attitude about what the practitioner thinks he or she might know, together with a belief that the practitioner does not have access to privileged information, can never fully understand another person, and always needs to learn more about what has been said or not said. In other words, for the collaborative practitioner, certainty of knowing becomes an illusion that can limit imaginatively and creatively knowing with the other.

A collaborative practitioner keeps in mind that knowing *with* is crucial to the dialogical process. In other words, the emphasis is on knowing with another in the moment instead of knowing about the other, their circumstances or what the preferred outcome should be beforehand or better than the other. A collaborative practitioner is aware of the risk that such pre- or better-knowing can place people in problem categories or identify them as types of persons (Gergen, Hoffman, & Anderson, 1996). Such knowing can limit a practitioner's ability to be interested in and learn about the uniqueness of that person and the novelty of their life. Riikonen and Smith (1997) summed up the ultimate risk of knowing: "Knowing [outsider knowledge] is the prime source of non-participation in dialogue" (p. 141).

A not knowing position does not mean a practitioner does not know anything or can discard or not use what she or he knows, e.g., theoretical knowledge, clinical experience, business experience, life experience. Instead, the emphasis is on the intent, the manner, attitude, tone and timing with which a practitioner's knowing is introduced. The introduction of a practitioner's knowledge is simply a way of participating in the conversation, offering food for thought and dialogue, and putting forward a possible way to continue to talk about what is being addressed. A practitioner pays careful attention to and remains coherent with the client's response. This includes being able to let go of our knowing if, for whatever reason, it does not fit for the client as well as being able to refrain from interpreting the non-fit in a judgmental manner.

Being public

Like all of us in everyday life, practitioners have private thoughts: professionally, personally, theoretically, or politically, based on experientially informed understandings. These thoughts and understandings influence how the therapist listens, hears and responds. From a collaborative stance, a practitioner is open and generous with their invisible thoughts, making them visible or what I call *being public*. Being public does not refer to what we traditionally think

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of as self-disclosure. Instead it has to do with the inner conversations that practitioners have with themselves about the client and the therapy. Being public with one's inner conversation can offer possibilities of things to talk about or ways to talk about them. It is one way for a practitioner to contribute and participate. I want to highlight "participate". The intent is to "take part in" in an unbiased manner, taking care not unduly to steer the conversation or doggedly to promote a viewpoint.

Being public has two primary advantages. Firstly, it is respectful, and I would say ethical, to put forward private inner thoughts and not hold them privately. I have often heard clients say that they wondered what their therapist was thinking but not saying. They wondered what was behind the therapist's questions. They felt that there was a private conversation about them of which they were not part. In all my practices I find that the client, the consultee or coachee wants to know what I am thinking. Secondly, and equally important, a therapist making private thoughts public has the potential of preventing him or her from collapsing into a monologue in which one idea or perspective takes up all his or her thinking room and seeing view. When the therapist engages in an internal monologue, the therapist can easily become closed to hearing the other and miss potential newness in meaning and understanding. The result can be that there is no evolution of what is said as happens in dialogue.

Being spontaneous and living with uncertainty

The form of conversation talked about in this article is a natural and spontaneous talk which has a back-and-forth nature to it. Each person's response is a response to the other and, in turn, informs and invites the other's response to it. The conversation is not guided by a technical manual, structured step process, pre-formed questions or other such strategies. In other words, how a conversation should look or unfold, e.g., its pace or the sequence of topics, is not predetermined.

When a practitioner and a client engage in more natural and spontaneous talk in which they jointly create the paths and determine the destination, there is always an uncertainty about their destination and how they will arrive there. What is created is different from and more than what could have been created by one without the other. Though a client may come in with a pre-defined problem and destination as well as expectations about how you will help them, it is likely that these will change through the course of the therapy conversations. As conversational partners, walking alongside each other, client and practitioner coordinate their actions as they respond with each other. Hence their path and destination are unpredictable and uncertain. What the path will look like, the detours along the way and the final destination will vary from client to client, from practitioner to practitioner and from situation to situation. That practitioner and client walk alongside each other and mutually engage in a collaborative and dialogical story-telling process is part of the intrinsically transformative nature of the therapy.

Mutually transforming

I stress the mutuality of the relationship and the conversational process. In this kind of withness, and relational and dialogic process, each party is under the influence of the other (s) and hence each party, including the practitioner, is as much at risk for change as the other: the process is not one-sided or unilaterally driven by either party. Equally, the practitioner is

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not passively receptive: he or she is actively involved in a complex interactive process of continuous response with a client, as well as with his/her own inner talk and experience. In other words, as conversational partners, we continually coordinate our actions and are influenced by the other we respond with.

Orienting towards everyday ordinary life

Over my years of practicing in various contexts and cultures, I have come to believe that therapy and other practices such as education, organization development and research can be more like everyday ordinary life. Though they take place in particular contexts and each with a particular agenda, therapy, for instance, does not need to be a sacred event with high priests and commoners. It can resemble the way we interact and talk in daily lives or, in Edwards (2005) words, the "naturally occurring interactional talk . . . through which people live their lives and conduct their everyday business" (p. 257). In everyday life, as Wittgenstein (1953) suggests, we search for how to know our "way about" and how to "go on". In all of our practices, participants strive for ways to move forward and carry on with their lives.

I have found it helpful to have a positive outlook regarding the people who I meet, regardless of their histories and circumstances. This includes a belief that each person has the capacity to lead a satisfying life and to view the human species as naturally resourceful, resilient and desiring of healthy relationships and qualities of life. I have also found it helpful to view discourses of pathology and dysfunction as constraining, as I believe that our language, our words, our descriptions partly form the person we see and hear. I want to see and hear each person and each member of a family or other system with fresh eyes and ears. I want to meet each as someone I have not met before.

The above suggests that therapy move from a hierarchical-dualistic, expert/non-expert model to a more egalitarian encounter in which people maintain dignity and pride and, with reference to one of the themes of the World Congress, maintain their history, language and culture.

TWO EXAMPLES OF COLLABORATIVE PRACTICE

I find that clients are far more resourceful and inventive than therapists sometimes give them credit for. Their after-therapy session thinking and acting is often unpredictable and surprising. I want to be careful to trust them and not get in their way. I offer excerpts from follow-up interviews the day following consultation sessions with two clients. The interviews were conducted to learn about the clients' experiences of the consultation and their thoughts and actions afterwards. University faculty who had observed the sessions did the interviews and the interviews were recorded. The clients' words illustrate the unpredictable and surprising nature of dialogue. Though these particular clients may not seem to have "difficult" problems, in my everyday practice I use the same collaborative approach with clients who present with circumstances such as school phobia, marital distress, depression and psychosis.

The implicit becomes explicit

I consulted with a young woman who was just starting out in her career and who was trying to make a decision about whether to have children or not. She was living in the United States and both her family and that of her husband lived in other countries on two different

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continents. Her mother happened to be in town and since she had mentioned that her mother was one of the people that she had talked with about her dilemma, I wondered if she wanted her mother to come with her. Since they had talked about the un-decidable decision before, she felt she would not be saying anything that her mother had not heard before or that she did not want the mother to hear. Her mother came and I asked the daughter how she would like the mother to participate in the session; she said that her mother could "just listen" and the mother agreed. I then asked if it would be okay if at some point I might want to speak with the mother. Both said it was okay.

The narrative fragments of the young woman's story touched on many things, including mothering, societal norms, dreams, decision-making, support systems and family values, among others. I learned a lot about the family, whose members seemed to have warm and caring relationships and to really enjoy each other. As we were near concluding the session, I spoke with the mother. I asked if she would share some of the things she had been thinking as her daughter and I talked. Tearing, she said that she had been thinking about her family and her three children and how responsibility was a dominating value in their family. She was very grateful for having the opportunity to listen to the conversation between her daughter and me, saying "There were many things that I thought and felt. One was the issue of responsibility and especially maternity and raising a child." She also said she felt a need to talk with her husband and all of her children. I had no need to ask why or about what.

The following day the mother contacted me to tell me what she happened after the session. She had spoken with her other two children, a son and a daughter who were grown and married, and with her husband. She continued:

> The implicit became explicit, not during the therapy session but afterwards . . . I don't know why but I felt the need to talk with my family so they would not feel so much responsibility. [The session] brings me to a point where I have to see my daughters and son in a different way . . . In the last few years all of traveling and vacations have been around our children: their moving, weddings, babies. I told my husband that we should travel alone.

As far as the daughter's experience of the session and what happened afterwards, she said "just the fact that I took the chance to speak was very liberating, very freeing". In summary, she no longer felt a prisoner of an "either–or" decision about having children.

I'll be meeting my father tonight for dinner

I consulted with a thirty-something professional man about his struggle to be independent of his family, particularly his father, who was a widower. He and his father had been estranged ever since he moved out of his father's house as a way of being more independent. He avoided contact with his father because he felt guilty having done so. We talked about his father, his family, and various aspects of his life, touching on many subjects. Here are some of his words from the follow-up interview the next day:

> After the interview, I called my father to arrange dinner. I'm looking forward to seeing him . . . I didn't think too much after the session, I was real busy with other stuff. That will happen later when I have some quiet moments . . . it's more like things are three-dimensional now, whether it leads me to peace or not, I do not know. But it's like I re-evaluated, reinterpreted my relationship with my father, like it almost adds

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> another dimension . . . stereoscopic . . . my life horizons are being broadened – more angles from which to see. Harlene didn't suggest anything about a next move; that gives me the autonomy to decide. She respected that I know what's best for my relationship with my father. She wouldn't know. I'm the one who knows best.

Reflections on these examples of dialogue as an inherently transforming process

Dialogue is a relational activity that, as Hoffman (2007) and Shotter (2010) suggest, requires a withness–thinking–understanding–speaking–acting. Transformation is inherent though unpredictable in this process.

What a client comes to therapy to address and attain may change. As new meaning and understanding evolve, the idea or experience that a client has of a "problem" as well as the imagined solution may dissolve. They may therefore develop a different sense of a problem and develop different actions to consider or carry out. The change or transformation does not necessarily have to be in thought, action or in any other shape that might be preferred by a therapist. What is important is that it is a newness that the client has participated in constructing and that it has relevance for them.

Both of the consultations above had "carry-over" into the everyday lives of the clients – and, in the first example, the mother of the client involved – though the nature of the carry-over was neither planned nor predictable. Both clients created their own unique carry-over, their own germination of what began for each in the session. Each created a next step that was spontaneous, natural and fitting to their circumstances and needs – steps which, in my experience, will be sustainable (to the extent that anything dialogic can be sustainable since it is a continuing process) because they did it.

For the mother of the young woman a significant change outside of the session had begun even though she was not actively engaged in the spoken conversation between the daughter and me. She had listened and watched, as we always do; and had carried over the potential of her silent, inner talk to spoken talk with her family members.

For the man worried about the situation with his father, in the session he began to have some new ways of thinking about his father and his relationship with him that, as he said, he had not had time to develop but he had acted on: he called and invited his father to dinner. I trust that this was a turning point for him in which he could have the kind of mutually satisfying relationship with his father that he indicated he would like to have and still maintain or have a sense of independence.

Both examples illustrate dialogue as an inherently transforming process: a means to unpredictable and spontaneous novel ways of being, thinking, speaking, acting and relating. Moreover, both examples exemplify the importance of trusting a client and not getting in their creative way. To paraphrase Wittgenstein (1953), dialogue allows each of us to find ways to go on from here. So, perhaps this is what is helpful in dialogue: we find ways to go on – or, at least we have a sense or hope that it is possible.

CONCLUSION

If a practitioner assumes a philosophical stance such as I describe, they will naturally and spontaneously create a metaphorical space and polyphonic process that invites and

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encourages conversations and relationships in which clients and practitioners "connect, collaborate and construct" with each other. In so doing, each member will have a sense of participation and belonging which, in turn, brings a sense of ownership and responsibility; and all combine to encourage unique, effective and sustainable outcomes. (By sustainable I do not mean permanent or static outcomes as that is not the nature of dialogue, therapy or life!) Because the philosophical stance becomes a natural and spontaneous way of being as a therapist, theory is not put into practice as such, and therapists do not employ across-the-board techniques and skills as we usually think of them. Instead, the stance flows from a set of philosophical assumptions that inform a way of being "with" in relationship and conversation that is collaborative and dialogic, making practice an event – and an experience – of withness that has relevance for people's everyday lives as determined by them. Collaborative practice consequently encourages and promotes a therapy system, process and relationship that is less hierarchical and less dualistic (than others), in which people participate on a more equitable, participatory and mutual basis. Together with similar conversational/dialogic approaches, collaborative practice challenges psychotherapy traditions, the contexts and systems they create and the authority that comes with them: it is this that is political. Finally, as Hoffman (2007) has suggested, "there is no end point toward which this movement of ours is trending" (p. 78).

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