Therapist Positioning and Power in Discursive Therapies: A Comparative Analysis

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Abstract   The "discursive turn" in therapy gave the therapeutic relationship its deserved significance, which was implied but never fully recognized in traditional therapy literature. The exception would be the writing of Rogers, Satir, and Whitaker. Therapists' actions in relation to clients became the *topic* of critical analysis and reflection rather than a *resource* for addressing some underlying inter- or intra-psychic forces and processes. This paper focuses on the issue of the therapist's relational engagement with families, particularly the notion of therapist power, as conceived within three discursive approaches to family therapy: narrative, solution-focused, and collaborative.

Keywords   Postmodern/discursive therapy · Collaboration and power in the therapeutic relationship · The therapist's role and positioning

Introduction

It is only rather recently that family therapists have come to recognize explicitly the importance of the therapeutic relationship.[1] As Flaskas remarks, "The therapeutic relationship did somehow fall off our *theory agenda* in the first 30 years" (2004, p. 14). Due to a number of theoretical developments in the 1980s, the topic of the therapeutic relationship has entered the discussion. The most significant shift has concerned the depiction of that relationship as a collaborative endeavor (Anderson 1997; Hoffman 1995; McNamee and Gergen 1992). While traditional therapy literature has focused almost exclusively on clients' collaboration (read compliance) with therapists' interventions, practitioners inspired by feminist, constructivist, and social constructionist perspectives often have

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[1] The exception would be the writings of Virginia Satir (1983) and Carl Whitaker (Whitaker and Keith, 1981).

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prioritized *their* collaborative positioning[2] in relation to clients (Goldner 1991; Hoffman 1992). It is for this reason that postmodern or discursive[3] therapies (Strong and Paré 2004) sometimes are referred to as "collaborative" (Anderson 2001; Perlesz and Brown 2005). This reflexive focus is not surprising considering that discursive therapies emerged partly in response to the traditional conception of therapists as unbiased and value-free experts capable of defining the reality of clients' situations and experiences "over the heads" of those clients.

Some have proclaimed that discursive therapies (e.g., narrative, collaborative,[4] solution-focused) have overcome the problem of therapist power (Gibney 1996). By minimizing or completely abdicating their "expert" positioning in relation to clients, discursive therapists distinguished themselves from more traditional approaches to family therapy (Anderson 1997; de Shazer 1994; Hoffman 1995). Others questioned the extent to which this non-expert position can be achieved in therapy (Golann 1988), or whether it is in itself an expression of therapist power (White 1991). Still others wondered whether therapists should use their culturally elevated position to advance their political agendas, such as challenging social inequality and oppression (Guilfoyle 2005). Evidently, the debate about power in discursive therapies is far from being resolved.

While discursive therapists have had plenty to say about therapist power, little effort has been made to systematically compare and contrast their perspectives (exceptions, Flaskas 2002; Gibney 1996; Guilfoyle 2003; Monk and Gehart 2003). The most notable of the existent comparisons are Monk and Gehart's (2003) discussion of the epistemological stances of narrative and collaborative therapists, and Guilfoyle's (2003) discussion of post-structural, rhetorical, and dialogical ideas and their application to the practice of collaborative and narrative therapies. Most of these critiques focus on specific issues pertaining to therapist positioning and power. This article offers a more comprehensive comparative outlook on how discursive therapists distinctly envision their relational engagement with families. My aim is not to offer ideas for reconciling these divergent perspectives, but simply to highlight assumptions behind various discursive therapists' conceptions of power and their implications for practice. This comparative analysis constitutes *my* interpretation of the stances on power by proponents of various discursive approaches and may not correspond exactly with the discursive writers' intentions for being understood. Also, by offering a unified account of each discursive approach, I inevitably have minimized the diversity of ideas and practices within each approach.

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[2] "Positioning" is a momentary assumption of certain rights and obligations with respect to what sorts of things a person in that position can say or do. Discursive positions are locations from which people engage others as they interact (Davies and Harré 1990). For me, positioning is a fluid, interactive process contingent upon the efforts of all people in interaction. As Winslade points out, "Any position in a relation creates an implicit (even if not explicitly stated) platform for another to respond from and gestures towards the other an invitation to stand upon that platform in making a response" (2005, p. 353). Therapists' actions in interaction are shaped by clients' preceding actions (and the entire conversation up to that point or even previous conversations) and are, in turn, shaping of clients' responses and vice versa.

[3] The term "discursive" refers to *what* people say and *how* they say it in communicating with each other.

[4] Discursive or collaborative therapies in general are not to be confused with the particular discursive approach known as "collaborative language systems." Harlene Anderson, one of its developers, has recently shortened the title of this approach to "collaborative therapy" (Anderson 2005).

Therapist Positioning Across Discursive Therapies

While distinct foci, aims, assumptions, and practices characterize various discursive approaches, there is a common philosophical foundation that places them under the unified umbrella of postmodern therapies (Anderson 2003). Discursive therapists share the preference for the metaphors of text, narrative, or discourse; skepticism with respect to discovering singular objective truths; an emphasis on the prominent role of language in the everyday constitution of meaning and action; the view of problems and solutions as evolving socio-cultural practices; and therapy as a process of mutual influence and transformation. These therapists advocate for a pragmatic and non-pathological approach to working with families. They respect clients' idiosyncrasies, preferences, and priorities and focus on clients' expertise and capacity to implement desired changes. Most importantly, discursive practitioners view their own use of language in therapy as *constructive* of the "reality" of clients' lives, identities, and relationships, rather than viewing it as objectively *reflective* of that reality. What therapists say or do in therapy and how they say or do it brings forth and legitimizes particular versions of clients' experiences and life events and passes over other versions (Anderson and Goolishian 1988; White and Epston 1990).

Despite these commonalities, there are some substantial, though perhaps subtle, differences in the assumptions and practices of these approaches, specifically pertaining to their conceptions of therapist power and positioning. Such differences revolve primarily around two issues: the therapist's *intent* in relation to clients, and the conception of, and emphasis given to, socio-political factors (context)—including *power* in the therapeutic relationship—in the formation of human experience, subjectivity, and action. Both of these issues relate to another consideration, namely, how the client is distinguished and configured as part of therapy. It is the discussion of these two issues to which I now turn. This discussion will be accompanied by a brief selective overview of key theoretical assumptions characterizing each discursive approach.

Narrative Therapy

Narrative therapy (NT; Freedman and Combs 1996; Parry and Doan 1994; White 1991, 1995; White and Epston 1990) was developed by family therapists Michael White and David Epston in the 1980s. This approach has philosophical and theoretical roots in post-structural, postmodern, and systemic traditions. French philosopher Michel Foucault's insights, in particular, have shaped the emergence and expansion of the theory and practice of NT.

Foucault (2003) argues that people are "disciplined" to act and talk normatively in ways consistent with elite or institutional conceptions of effective action and optimal knowledge. He maintains that disciplines, such as medicine or psychology, are not mere collections of theories and techniques for curing illness, but are political and moral arbiters of health and normality, or of *the model person*. In describing how power is sustained in a society, Foucault (1979) states that subjects are governed and disciplined through the voluntary participation in ever evolving relations of *knowledge/power*, that is, normative social practices and linguistic forms that shape and constrain ways in which people can act and describe themselves. It is in and through the operations of power/knowledge that people are compared, hierarchized, and differentiated or, in short, *normalized* (Foucault 1979).

Clients become a vehicle of power/knowledge by engaging in self-surveillance. They turn themselves into objects of self-policing (Foucault 2003) and act in ways consistent with normative client conduct (e.g., seek help from expert practitioners, view themselves as carriers of problems). By offering normative rules and comparing people in relation to these rules, power/knowledge relations position people in ways that restrict options for these people's authentic conduct and self-definition. In psychology, power/knowledge is sometimes referred to as *psy-complex* (Guilfoyle 2001; Rose 1990). *Psy* includes psychological jargon, such as self, psyche, psychopathology, consciousness, and personality, and practices aimed at management and transformation of human subjectivity. Gradually, *psy* gets internalized and becomes a part of people's vocabulary and everyday expression (Rose 1990).

While *psy* is not distributed unilaterally but rather via the net of social relations, professionals play a special role in such distribution. They employ a variety of rhetorical strategies and resources to psy-chologize, pathologize, and individualize clients (Foucault 1979). Therapists become involved in reproducing the dominant culture through promoting its normative practices. Foucauldians argue that clients' resistance in therapy to *psy* technologies is often faced with the disciplinarian efforts of therapists. When clients defy the helping efforts of therapists, these therapists punctuate clients' actions in terms of their favored professional discourses instead of taking clients' actions at their face value (Guilfoyle 2001). NTs believe that psychological theories often inadvertently perpetuate clients' problems. By contrast, they attempt to bring forth clients' own modes of self-knowledge and replace therapists' stories of healing with stories preferred by clients (White and Epston 1990), recognizing that all stories and knowledge are inevitably shaped by culture.

To accomplish this, NTs adopt a non-expert (yet influential) stance of curiosity, interest, understanding, persistence, and positive assumptions (Monk et al. 1997). They conceive of a client "as the courageous victor rather than the pathologized victim" (Monk 1997, p. 4). These therapists avoid pathologizing, labeling, and classifying clients and prefer to separate people from their problems (e.g., "a person with depression" versus a "depressed person"). The therapist role is to co-edit clients' stories (Parry and Doan 1994). Co-editing does not mean editing the story for clients, but providing conversational space for clients to re-edit or re-author (White 1995) their stories in their own ways.

Therapist's Intent: Challenging Social Injustices

The primary agenda of narrative therapists is to empower[5] clients and to facilitate their liberation from dominant cultural stories (Monk and Gehart 2003; White 1991; White and Epston 1990). Therapists are "sociopolitical activists" (Monk and Gehart 2003) who acknowledge clients' resources and invite clients to join them in the battle against the problem-saturated story (Monk 1997). While NTs' agendas and associated therapeutic tasks seem to be, for the most part, *pre-formed*, such agendas are not unilaterally imposed or imported into the interaction. On the contrary, therapists seek collaboration from clients in the accomplishment of their agendas and modify interventions to fit clients' emergent preferences and understandings.

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[5] From a discursive perspective, it would seem reasonable to view "empowerment" not as something unilaterally done to the client by the therapist but as an interactive process, whereby the client's sense of mastery and agency are developed and expanded in the course of dialogue.

Some have raised the question regarding how open NTs are to abandoning their empowerment agenda when it does not agree with clients' agendas for change. It has been suggested that NT (some ways of practicing it) may inadvertently turn into a dominant and oppressive narrative of its own (Gibney 1996; Hayward 2003; Larner in Flaskas et al. 2000). For collaborative therapists (CTs; Anderson and Goolishian 1990), power and control are inevitable if the therapist's agenda is to move clients from point A (oppressed) to point B (liberated). They argue that agendas need to arise from within a conversation to ensure that clients' emergent preferences for mutual work are genuinely consequential in shaping therapy (Anderson 1997). Those informed by narrative and post-structural ideas, in turn, argue that therapists' reluctance to take an explicit political stance is a political stance of its own (Tomm 2003). They further insist that if therapists reflect back to clients only what clients raise (subjugating stories of identity), there is a risk of colluding with oppression and inequality (Hare-Mustin 1994). In response, CTs maintain that, similar to narrative and other therapists, they have (and express) political concerns and commitments. However, CTs prefer to do their "political 'knowing' *tentatively* [Anderson 2001], realizing there are multiple ways to understand 'the political' and that all ... understandings are constantly shifting, open to further influence, always incomplete" (J. DeFehr, personal communications, May 6, 2007).

Focus on the Broader Socio-Cultural Context

NTs thus refuse to limit themselves to locally emergent understandings and agendas; they instead approach discourse from an ideologically conscious position with the goal of unmasking subjugating and oppressive discourses and practices (Hare-Mustin 1994; Monk et al. 1997; Parry and Doan 1994; White 1991). Guilfoyle (2001), for example, argues that even if therapists' attempts to locally challenge *psy* discourses are successful, at the macro-level these therapists still remain *psychotherapists* or experts to their clients. Foucault (2003) similarly suggests that while professional discourses or even the whole system of orientation of the 'gaze' (as in postmodern therapies) transform, the gaze remains a necessary organizer and normalizer of human experience.

Some have suggested that NT tends to retain essentialist elements in its theorizing (the therapeutic relationship is inherently unequal; clients are oppressed and in need of liberation; therapists are essentially more powerful) that are incompatible with the social constructionist perspective (Gremillion 2004) with which NT claims to be affiliated (Freedman and Combs 1996; White 1995). Others have argued that the notion of "power" is a way to punctuate or describe human relations and not a real entity to be discovered and challenged (Watzlawick et al. 1967). NT has been critiqued further for "anthropomorphizing" cultural discourses and power relations (T. Strong, personal communications, September 29, 2005). These characteristics are presented as *offering* subject positions, *privileging* certain versions of reality at the expense of other versions, and *sustaining* social structures. Human agency is often downplayed and presented as encapsulated, passive, or naïve. Overall, it has been pointed out that NT has struggled to "avoid positing 'authentic' [completely unrestricted] selves and assuming social determinism" (Gremillion 2004, p. 190).

Similar to discursive practice, discursive research has been characterized by two competing theoretical camps: *conversation analysis* with its micro ("bottom-up" or deductive) emphasis on the context, and Foucault-inspired *critical discourse analysis* with a macro ("top-down" or inductive) approach (Speer 2001). From the macro perspective, researchers must examine not only how culture is enacted or constituted through people's

everyday actions, but also how culture positions and constrains people to act and think in particular ways (Wetherell 1998). Conversation analysts (CAs) have critiqued critical discourse analysts for advocating the position characterized by discursive determinism, a view of the socio-cultural context as a bucket somehow externally constraining individuals' actions and experiences (Heritage 1997; Hutchby and Wooffitt 1998; Schegloff 1997). By contrast, CA practitioners treat gender, race, power inequalities, oppression, professional roles, and identities as characteristics to be "worked up and made relevant in the interaction, not as external determinants" (Speer, p. 113). For them, there is *no* socio-cultural context outside of people's actions in interaction. Context is dialogically "performed" (developed and sustained) by people in the back and forth of their talking. Hence, CA proponents are interested in the "[social] *structure within discursive practices*, rather than structure apart from, above and before discourse" (Linell 1998, p. 5). While skin color, gender, historical events, organizational policies, and other socio-cultural variables certainly impact who can do what and how in interaction, micro analysts are more interested in *how* people locally evoke, interpret, and manage these factors (Schegloff 1997).

From a CA perspective, ordinary conversations generally are carried out in unpredictable ways and very little is known in advance about who will say what and how, as everything is negotiated on the spot (Sacks et al. 1974). However, in institutional settings (e.g., counselling, school, and court), participants tend to deploy a specific turn-taking organization (e.g., the unequal distribution of questions and answers), shaping or constraining opportunities for action and meaning. Participants are not inherently constrained by, or passively positioned within, this conversational organization (Heritage 1997). Instead, they mutually orient to and draw on this organization in their attempts to accomplish efficiently the business at hand (e.g., assess the client's situation, formulate the problem/concern that brings the client to therapy).

Inevitably, the mutual deployment of a specific interactive organization does afford some parties greater opportunities to pursue their agendas and interests, and limits the tolerated range of available options for other parties. Although therapists tend to monopolize certain initiatives, such as questions, proposals, and topic changes (e.g., Buttny 1996; Peyrot 1995), there is no guarantee that these professionals will assert the rights to which they are "entitled" or that clients will align with or support these asserted rights (Heritage and Raymond 2005). For a particular organizational structure to progress (therapists' prerogative to initiate the beginning or ending of the session), clients' ongoing cooperation is required. Discursive resources and opportunities are available to clients to resist professionals' routine practices and rhetorical strategies, and to challenge the associated hierarchical order (Davis 1986; Grossen and Apothéloz 1996).

Macro-oriented researchers argue that researchers run the risk of overlooking how certain prerogatives and rights are afforded to certain people, and not to others, in the first place if they focus exclusively on the participants' local orientations to issues of inequality (Wetherell 1998). Also, oppressive practices operate in ways that undermine potential resistance to them; they are formulated as natural, unbiased, and just. Marginalized parties are not likely to resist, or even orient to, the workings of these practices (Frith 1998). Consequently, it becomes the responsibility of the researcher to read the data in ways that recognize and challenge oppression (Billig 1999).[6]

The stance of NTs corresponds closely to that of macro-oriented researchers, while CTs would probably endorse assumptions advocated within the micro research camp. On the

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[6] I have only touched on certain aspects of this micro–macro debate. For further details see, for example, Korobov (2001), Schegloff (1997), Billig (1999), and Wetherell (1998).

whole, the epistemological stances on power of macro and micro approaches to research and practice seem incommensurable. If NTs were to abandon their assumption that the therapeutic relationship is characterized by inequality and focus exclusively on how "transitory" asymmetries in meaning-making are locally enacted, they would be adopting the position of CTs on the issue of power, namely that power can but does not have to be a part of therapy. Likewise, if CTs were to have an agenda of challenging societal inequalities (decided upon prior to the client's entry into therapy), they would be abandoning their focus on meaning as *emergent from within* the interaction, rather than as being pre-determined by more global socio-cultural concerns. In highlighting these differences, I do not mean to advance one approach over another. Rather, my intent is to show that these approaches are based on different premises about discourse and how to participate in that discourse.

Collaborative Therapy

Collaborative language systems practitioners or, in short, collaborative therapists (CTs; Anderson 1997; Anderson and Goolishian 1988, 1990; Hoffman 1995) argue that the systemic, cybernetic view,[7] which has permeated family therapy since its emergence, is a theory of ordered control and therapist power—that is, it leads families towards some "normative" ideal (e.g., systemic balance). In their attempts to challenge the power differential in the therapeutic relationship, CTs moved from the domain of cybernetics to the domain of meaning (Hoffman 1995). From the perspective of CT, human beings exist only in language (Anderson and Goolishian 1988). Families organize themselves around problems and produce (talk into being) systems of meaning pertaining to these problems. Families who come to therapy typically are "stuck" within these systems of meaning and are unable to go on in ways they desire or prefer. As families, jointly with therapists, come to describe and make sense of their living situations differently, the problems dissolve or new possibilities for living and relating emerge, rendering the initial problem irrelevant.

    CTs thus equate therapeutic change with an evolution of meaning through dialogue (Anderson and Goolishian 1988, 1990), and perceive shifts in meaning as a byproduct of collaborative relationships and dialogic conversations (Anderson 1997, 2001, 2003; Anderson and Goolishian 1990). Therefore, within CT, the conventional *change-oriented* approach is replaced by a *context-oriented* approach (Anderson 1997, 2001; Anderson and Goolishian 1990; Hoffman 1995). While exploring clients' perspectives, CTs do not try to facilitate change in clients or to elicit a particular outcome, direction, or answer from the clients. Therapeutic goals and tasks emerge from within the conversation rather than being imported from the outside (Anderson 2001); they are mutually agreed upon and continuously and collaboratively revised.

    CTs use *non-interventionist interventions*. They do not seek to intervene at all, instead preferring to simply converse with clients without trying to steer a conversation in a particular direction. Questions arise out of genuine curiosity to know more, rather than being used strategically for the purpose of eliciting certain information in order to fit the clients' accounts into pre-established categories (Anderson 2001). CTs prefer to view dialogue, and not the therapist, as the agent of change. In contrast to narrative and solution-focused therapists, collaborative practitioners question the possibility of the therapist

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[7] "Systemic" refers to how client problems are understood in relational context, as products and processes of patterns of relational interaction.

having power to control, cure, or empower clients (Anderson 2001; Anderson and Goolishian 1990).

It has been argued that all therapists, including CTs, have some pre-formed agendas and normative ideals imported from outside of the interaction, whether or not such ideas and agendas are acknowledged explicitly (Atkinson and Heath 1990). Some have alleged that CTs might become too certain in their uncertainty and overly knowing when it comes to their not-knowing (Cecchin et al. 1992; Larner et al. 2004). There is a potential for a not-knowing stance to constrain therapists' responsiveness in relation to clients. These critics suggest that not-knowing therapists seem to decide ahead of time to not know too quickly and to let clients be the primary knowers of their realities. Such an agenda seems to be imported from the outside. It appears to contradict the central premise of CT to avoid pre-determined agendas. In contrast, a genuinely not-knowing stance would mean that therapists know that they do not know better than clients what those clients want. This includes clients' preference to, at times, not know and to not be positioned as experts on their life.

Therapist's Intent: Facilitating Dialogue

CTs have replaced an earlier conception of their professional role as a "participant manager" of a conversation (Anderson and Goolishian 1988) with a conception of a "conversational partner" (Anderson 1997, 2001; Hoffman 1995). The CT does not manage anything, but simply has a conversation with the client about the client. CT developers argue that dialogue and collaboration are more likely to take place if the therapist adopts a stance of "not-knowing" and uncertainty in relation to clients (Anderson and Goolishian 1988). The concept of not-knowing has often been misunderstood as a technique, method, ignorance, withholding knowledge, avoiding suggestions, or forgetting knowledge (Anderson 2001). For Anderson, not-knowing implies that therapists move away from collecting clients' stories in order to fit them within therapists' favored theories and agendas, and instead understand such stories from the clients' frames of reference (Anderson 2005). While both therapists and clients contribute to and transform in the interaction, a conversation in therapy is ultimately *about* the client and *for* the client. CTs recognize the inevitability of therapists being biased (Anderson 2001) yet prefer to give primacy to clients' meanings and biases, including how clients utilize and make sense of therapists' professional knowledge.

Some writers have considered therapeutic change as taking place at the crossroads of differing perspectives or voices (Cecchin et al. 1992). One way in which clients can experience shifts in their familiar ways of being and relating is by adopting therapists' ideas. Although CTs argue that every voice in therapy is worthy of consideration, including that of the therapist (Anderson 2005), these therapists, at the same time, seem to encourage practitioners to continuously adjust their understandings to those of clients (Goolishian and Anderson 1992). Such ongoing adjustment presumably would make it difficult for therapists to formulate and articulate their positions and for clients to benefit from therapists' offerings. Can clients become informed in the context of therapists' ongoing attempts to be informed by clients? This has been one of the criticisms of CT—the tendency to exclude the therapist's expertise and rhetoric—that it turns a conversation into a one-way (monological) interaction (Mason in Hardham 2006; Rober 2005). In response to these criticisms, Anderson (2005) argues that, within CT, the therapist's expertise is not denied or excluded from interaction but instead is re-conceptualized in conversational terms as the capacity to foster collaborative interactions tailored to clients' meanings and preferences.

The therapist is a partner who walks alongside the client co-searching for understandings or ways of being that will help clients live their lives in preferred ways. She adds that CT is dialogical and interactive, rather than unilateral, which it has been accused of being. More recently, Anderson (2007) also has described CT as a process of *negotiation* of understandings, perhaps addressing the aforementioned concerns.

It is noteworthy that therapists' depiction of their engagement does not necessarily represent their actual engagement.[8] Studies examining communication between discursive therapists and clients demonstrate that therapists' relationships with clients are more hierarchical and directive or educative than these therapists' own depiction of their relationships (Friedlander et al. 2000; Gale 1991; Murphy et al. 2006). For example, Murphy and colleagues (2006) examined the power practices of collaborative (Harlene Anderson), narrative (Michael White), and other (e.g., structural, feminist) "master" therapists. These researchers concluded that all therapists exercised power, conceptualized as the ability to guide clients' responses, with most power/control flowing in the direction of clients. White was found to use power minimally as compared to other therapists, including Anderson. At the same time, Anderson was found to engage in a so-called "empowerment pattern" (therapists' submissive message followed by clients' control message), which fits well the idea of uncertainty and not-knowing promoted within CT.

To recap, one point of departure in the stance of CTs from the stance of other discursive therapists lies in the therapist's *intent* (Anderson and Goolishian 1990). While virtually all discursive practitioners equate change with the construction of new meaning in dialogue, CTs *do not seek* to challenge the dominant story (as in NT) or to encourage solution-talk (as in solution-focused therapy, SFT). Dialogue is not sought as the means to some end such as the emergence of the counter-narrative or the empowerment of the client. CTs treat dialogue as a worthy end in itself. Alternative stories and the client's sense of mastery may, or may not, be the outcomes of such generative conversations.

Focus on the Immediate Dialogical Context

CTs also place less emphasis, as compared to NTs, on history, culture, and tradition (Anderson 2003; Monk and Gehart 2003). They address larger socio-political issues primarily when clients deem them to be relevant and significant. CT proponents suggest that dominant and subjugating discourses and practices are not inherent features of therapeutic interaction, as argued by post-structuralists. These therapists do not question that culture shapes and constrains local meaning-making, yet argue that there is an ongoing dialectic between societal and local understandings (Anderson 1997; Anderson and Goolishian 1988; Monk and Gehart 2003). They add that it is impossible to predict ahead of time which, if any, socio-cultural factors will have a significant impact on what transpires in therapy. CTs insist that power can be a part of therapy yet that it does not have to be. The therapist does not have to assume a prescribed and theoretically determined role (Goolishian and Anderson 1992).

Both CTs and NTs recognize the significance of the socio-cultural context. Both consider therapy to be shaped (and constrained) by the socio-cultural context and at the same

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[8] As a social constructionist therapist and researcher, I believe that it is impossible to arrive at an accurate, objective perspective on what transpires in therapy. Researchers can only offer accounts or versions of what happens when therapists and clients interact, based on their favored theoretical and methodological commitments.

time to be shaping of such context (Anderson and Goolishian 1988; Guilfoyle 2003). Within CT, monologue (power) is distinguished from dialogue (collaboration) (Anderson 1990). CTs insist that monological interaction, associated with the therapist's use of rhetoric, inhibits the generation of new meaning, or change. Post-structural, dialogical, and discursive/rhetorical writers have questioned the notion of therapy as a purely dialogical process free of power and rhetoric. NTs maintain that, while culture is expressed and even transformed at the level of everyday action and meaning, it is not limited to that level (Guilfoyle 2003, 2005). They challenge the position of CT that power is comprised of one person influencing another (Anderson and Goolishian 1990), and question whether power *can* be eliminated through therapists' conscious efforts and whether it *needs to* be eliminated (Guilfoyle 2003). Discursive/rhetorical psychologists (Edwards and Potter 1992; Billig 1996) further argue that therapists' "innocent" adjustment of their understanding to that of clients is a rhetorical rather than purely dialogical move. For example, Antaki et al. (2005) examined therapy discourse and showed how simple summaries of the clients' talk afforded therapists opportunities to advance their own accounts and agendas by presenting them as neutral or unbiased summaries of the clients' offerings ("So, what you are saying is…"). For me, no matter how dialogical the therapist is, he or she is inevitably rhetorical and argumentative. The therapist's preference to avoid pre-formed therapeutic directions is one kind of direction or rhetorical move. All therapy talk, whether discursive or mainstream, can be viewed as argumentative and rhetorical, at some moments and in some ways. Having said this, I do think that discursive therapeutic practices constitute a distinct, collaborative kind of rhetoric.

Re-conceptualizing Dialogue

Perhaps it makes more sense to consider collaboration and power/rhetoric as being in a dialectical rather than dichotomous relationship (Larner 1995). I contend that power, viewed as the advancement of one's own perspective in a conversation (both the *what* and *how* aspects of such advancement), can be accomplished in the context of collaboration with other perspectives, rather than at their expense. Michail Bakhtin (1981) conceptualized perspectives or "voices" in dialogue not as excluding each other but as intersecting with each other in many different ways. When some voices are formulated authoritatively, their intersection with other voices is hindered. Even in these situations, other perspectives are not excluded from dialogue; they are organized around the authoritative discourse, interpreting, resisting, and praising it. Hence, for Bakhtin, communication is inevitably heteroglossic, or multivoiced, even if some voices end up being on the margins of a conversation. Overall, Bakhtin characterizes language by the simultaneous presence of forces that are *centripetal* (toward discursive unity) and *centrifugal* (toward discursive diversity).

Not only do these forces coexist in dialogue, they may be viewed as relying on each other for their continuing existence. The performance of power by one party requires the collaborative efforts of the other party, such as conformity or resistance (Dijk 1993). Besides, asymmetries—communicatively relevant and temporal inequalities in knowledge or participation—are inevitable features of dialogue and without them, collaboration and communication in general would not be necessary. Learning and development depend upon a person's ability to collaborate with, or temporarily depend upon, someone with more extensive knowledge/power (Linell and Luckman 1991). While power can be characterized by the reciprocity of efforts, such reciprocity certainly can be unequal.

Starhawk ([1987](#)) distinguished between *power-over* and *power-with*. While connecting power-over with coercion and domination, Starhawk linked power-with to the influence of a strong individual in a group of equals. She suggested that power-with is realized through the other's willingness to follow and be led temporarily by a member of a social group. Power-with is necessary for creating alternative understandings and is a common attribute of social relations.

Within discursive therapies, power-over and power-with have been equated and *all* power has been viewed as inherently negative (Proctor [2002](#)). Both NTs and CTs have largely focused on power as a constraint and have overlooked power as a constitutive force (Foucault [1980](#)). Solution-focused therapists (e.g., de Shazer [1991](#)) uniquely recognized that therapist power can have therapeutic effects if exercised sensitively and appropriately. Tomm ([1993](#)) similarly suggested that therapists' ideas (restrictive or outer-defining power) can be internalized by clients and become a part of those clients' own story of wellness (constructive or inner-defining power). Power needs to be enacted in respectful and responsive ways for it to avoid turning into dominance or abuse of power; it needs to be shared, with therapists and clients taking turns at offering their expertise. From this dialogical perspective, power is necessary for change and development, yet may easily turn into power abuse or dominance (Guilfoyle [2003](#); Dijk [1993](#); Starhawk [1987](#)). This may occur when people's attempts to resist power are ignored or minimized (Guilfoyle [2003](#); White [1991](#)). Many discursive therapists have recognized and addressed this danger by making their interventions "transparent" and thus contestable by clients, introducing their ideas tentatively, paying close attention to what clients do with their ideas and proposals (refuse, agree, challenge, etc.), adjusting their talk in light of clients' responses, and so forth.

Overall, more recent developments within discursive therapies have led to re-conceptualizing therapy as a *dialogue of rhetorical forces* (Anderson [2007](#); Guilfoyle [2003](#)) rather than dialogue free of rhetoric. As Guilfoyle maintains, "Power relations … infuse dialogue, *without compromising the dialogical status of the interaction*: power and resistance work together to produce a dialogical interplay of forces" (p. 335). Gibney ([1996](#)) similarly argues, "Power must be used in loving ways—that is, it must be used in a way that increases the family's options" (p. 91). Larner and colleagues ([2004](#)) also encourage therapists' ethical uses of power. Relatedly, there has been a call to consider the client's active participation in shaping therapy content and process. What has been missing in the perspective of discursive therapies is a "language to describe the client's 'collaborative stance' as a more active participant in the collaborative process" (Perlesz and Brown [2005](#), p. 177). From a more encompassing perspective, collaboration is not the sole responsibility of the therapist, but a joint performance (Rober [2005](#)). In collaborative interactions, speakers jointly articulate, coordinate, and negotiate their positions to develop new understandings (Strong and Sutherland [2007](#); Sutherland and Couture, in press; Weingarten [1991](#)).

Solution-Focused Therapy

Solution-focused therapy (SFT; de Shazer [1985](#), [1991](#)) is a model of brief family therapy that emerged in the 1980s (O'Connell [1998](#)). It became a foundation for other solution-oriented approaches to therapy (Lipchik [2002](#); O'Hanlon and Weiner-Davis [2003](#)). SFT is about helping clients generate alternative choices, strategies, and beliefs. It is a future-oriented and non-pathologizing approach to addressing clients' concerns (Walter and Peller [1992](#)).

SFT is rooted largely in the theoretical insights and practical innovations of Milton Erickson and the Mental Research Institute associates (e.g., Gregory Bateson, Don Jackson, John Weakland, Jay Haley, Paul Watzlawick). It is a brief approach to working with families in which the focus on the present and the future replaces the traditional psycho-dynamic focus on the past. SFTs have noted that the role of the therapist in traditional models of therapy is to explore the problem (its cause, severity, or duration), and to generate solutions or specific ways of *getting away* from the problem. From this traditional perspective, the problem constitutes the focus of therapy and the solutions are grounded in and derived from this problem. By contrast, SFTs view solutions as disconnected from problems. They argue that assessment of the problem is not a prerequisite to finding a solution. These therapists go so far as to suggest that problem-talk further grounds the client in old problematic patterns of thinking and acting and makes it more difficult for the client to reach his or her therapeutic objectives (Friedman and Fanger 1991; Walter and Peller 1992). SFTs invite clients into an exploration of the pathway *toward* the desired future. They discard the question of "why this problem" and instead focus on narrative themes that maintain the problem and those that diminish it. SFTs therefore pay significantly less attention to clients' problem stories, as compared to NTs or CTs (Dickerson and Zimmerman 1993). The emphasis on solution-talk, exceptions to old patterns of thought and action, and client resources are key features that distinguish SFT from other therapies (Berg and de Shazer 1993).

Therapist Intent: Achieving Client-Preferred Outcomes

SFTs are "improvisational artists" (Selekman 2005) who refuse to be preoccupied with strict adherence to therapy models and who approach each case creatively, spontaneously, and playfully. Their posture is one of curiosity, openness, flexibility, gentle persistence, and attentiveness to cues that are in the direction of solutions (Friedman and Fanger 1991). Traditionally, SFTs have taken a strategic stance in relation to clients (de Shazer 1985). More recently, they have sought to establish a process of collaborative co-construction of goals and solutions in therapy (Lipchik 2002; O'Hanlon and Weiner-Davis 2003; Rowan and O'Hanlon 1999; Walter and Peller 1992). Collaboration is a shared responsibility. It is the client's responsibility to teach the therapist about how to join him or her effectively (O'Connell 1998). From an SFT perspective, the notion of client "resistance" does not exist. Whenever clients refuse to join therapists' interventions, such refusal constitutes a rich source of information in helping therapists adjust their approach to clients' unique preferences (Selekman 2005). On the whole, SFTs assume a more hierarchical position and a strategic intent in relation to clients (Anderson 2003; Dickerson and Zimmerman 1993) as compared to other discursive therapists. As de Shazer (1991) asserts, SFTs maintain control of the situation yet are flexible in their interventions.

SFTs view clients as experts on their own lives and therapists as experts at creating collaborative, solution-oriented dialogues (Lipchik 2002). Both therapists and clients are viewed as having power in the therapeutic relationship (O'Hanlon 1993). Both have equal opportunities to influence the direction of therapy. This does not imply that both will end up making use of these opportunities. Often, clients position themselves as powerless and vulnerable. Therapists may run the risk of marginalizing clients' resourcefulness and imposing their own expertise on clients. SFTs strive to empower clients to discover and use their own power (Rowan and O'Hanlon 1999). To accomplish this, they take on a non-expert position in relation to clients, similar to practitioners of CT and NT (Berg and de

Shazer 1993; O'Connell 1998; de Shazer 1994). SFTs downgrade their expertise by demystifying therapy and by welcoming and incorporating clients' expertise (O'Connell 1998). The intent is not so much political, as in NT, but more pragmatic. Unless therapists join clients in their understandings and preferences, change is unlikely to take place. Overall, SFTs do not find issues of power and social justice to be relevant (Dickerson and Zimmerman 1993). While encouraging the client's agency, SFTs do not consider it to be their job to liberate the client from oppressive discourses and power relations. They draw on a different set of assumptions for describing their practice and prefer to do what they think clients want them to do, namely, help clients solve their problems.

SFTs consider it to be their responsibility to use theoretical assumptions to guide the therapeutic relationship and interaction for clients (Lipchik 2002). For SFTs, "non-interventionist interventions," proposed by CTs, can diffuse the direction toward change. Posing random questions that stem from the therapists' immediate curiosity and "wondering here and there" (Anderson 2003) can interfere with "the solution-focused process rather than keeping it focused on solution [or change, more generally]" (Lipchik 2002, p. 47). Therapy is not just about maintaining a dialogue or learning from the client (de Shazer 1994). SFTs do not decide on the content of a conversation, but keep it steered in a direction that may help clients reach set objectives. These therapists hear most of what clients say yet listen for and respond only to what they see as potentially therapeutic and useful for these clients (Lipchik 2002).

Conclusions

Discursive therapies are often described as collaborative (Anderson 2001; Hoffman 1995; Perlesz and Brown 2005). Collaborative therapists propose to replace an expert-driven approach to working with clients with a client-driven endeavor (Berg and Dolan 2001). These practitioners substitute for "therapy" or "clinical interview" the terms "conversation" and "dialogue" to emphasize the flattening of the hierarchy in the professional relationship (de Shazer 1985; Walter and Peller 1996). Discursive practitioners argue that a distinct stance on the part of the therapist is required to develop a professional relationship characterized by mutuality and reciprocity of participation (e.g., Anderson 1997; Cecchin et al. 1992; Guilfoyle 2003; Weingarten 1998). Discursive therapists avoid confusing *their truths* with *the truth* (Goldner 1993), and present their knowledge as relative and contestable rather than as objective and undisputable. These practitioners propose a professional rigor of a distinct, conversational kind (T. Strong, personal communications, February 5, 2007). They recommend that therapists be rigorous not so much in terms of *content* (their knowledge or interventions) but more in terms of conversational *process*, that is, using professional knowledge in ways that fit clients' theories of change and preferences for therapeutic work (Duncan and Miller 2000; Weingarten 1998). Therapists do their "knowing" while closely attending to what clients offer in return and incorporating clients' emergent understandings, descriptions, and preferences into how both parties go forward.

In this article, I have reviewed three contemporary approaches to family therapy: collaborative, narrative, and solution-focused. I have discussed and compared positions on the issues of therapist power and socio-cultural context taken within each approach. While some discursive therapists adopt the non-expert stance of facilitators and reflective listeners, others acknowledge the inevitability of their expert positioning in relation to clients and assume responsibility for being active directors of the therapy process (Friedman

1993). Specifically, SFTs pursue a pragmatic, solution-focused agenda (Gale 1991) as compared to the political agenda of NTs. CTs avoid pre-determined (by therapists) agendas and prefer that agendas, goals, tasks, topics, or roles be collaboratively co-developed in the conversational back-and-forth of therapy. The issues of a more global context seem be of little interest to SFTs, unless they interfere with a solution-focused agenda. CTs recognize the potential impact of more global factors on what transpires locally and do not shy away from raising and discussing political concerns in the course of therapy, as long as such discussions are not imposed upon clients but are found to be *mutually* relevant and meaningful. NTs argue that avoiding politics is a political stance in itself and prefer to explicitly acknowledge and challenge social injustices.

Often therapists have preferred conceptual frames into which they and their clients may enter in the course of therapy. In discursive therapies, these frames are ideas of *possible* conversations and are not impositions on clients of what the clients should think, want, or do. While having distinct ideas about what constitutes good or helpful interaction in therapy, many discursive practitioners share a common destination—clients as "active mediators, negotiators, and representatives of their own lives" (White 2004, p. 20).

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