

The Client is the Expert: a Not-Knowing Approach to Therapy

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That is an interesting and complicated question. If a person like you had found a way to talk with me when I was first going crazy . . . at all the times of my delusion that I was a grand military figure . . . I knew that this [delusion] was a way that I was trying to tell myself that I could overcome my panic and fear. . . . Rather than talk with me about this, my doctors would always ask me what I call conditional questions. . . . [To which the therapist inquired, 'What are conditional questions?']

You [the professionals] are always checking me out . . . checking me out, to see if I knew what you knew rather than find a way to talk with me. You would ask, 'Is this an ashtray?' to see if I knew or not. It was as if you knew and wanted to see if I could . . . that only made me more frightened, more panicked. If you could have talked with the 'me' that knew how frightened I was. If you had been able to understand how crazy I had to be so that I could be strong enough to deal with this life threatening fear . . . then we could have handled that crazy general.

The words are those of a revolving-door treatment failure, a thirty-year-old man, Bill, who had been hospitalized on several occasions for what had been diagnosed as paranoid schizophrenia. His previous treatment contacts had been unsuccessful. He had remained angry and suspicious, and he had been unable to work for some time. Through much of his adult life he was sporadically on 'maintenance doses' of psychoactive medication. At the time he first consulted one of the authors he had once more been fired from a teaching job. More recently, the man had greatly improved and had been able to hold down a job. He insisted that his current therapist was different from the others and that he now felt more capable of managing his life. It was this conversational context that influenced the question, 'What, if anything, could your previous therapists have done differently that would have been more useful to you?'

In this conversation Bill was referring to his experience of therapy as practiced by the authors and their colleagues at the Houston Galveston Family Institute. This is a therapy that has been evolving over the last twenty-five years. During this time the

thinking has undergone a major shift away from the usual theories of social science that typically inform psychotherapy. The ideas in this chapter represent a current interest in an interpretive and hermeneutic approach to understanding therapy. Specifically, the therapist position of 'not-knowing' and its relevance to the notions of therapeutic conversation and conversational questions is discussed.

From Social Structure to the Generation of Human Meaning

Over the last several decades, developments in the systemic therapies have attempted to develop a conceptual framework that bypassed the earlier empiricism of theories of therapy. These developments shifted family therapy thinking to what is called second-order cybernetics and ultimately constructivism. Of late it has been our conclusion (Anderson and Goolishian, 1988, 1989, 1990a) that there are serious limits to this cybernetic paradigm as it informs therapy practice. These limits are principally in the mechanical metaphors underlying cybernetic feedback theory. We note that within this metaphor there is little opportunity to deal with the experience of an individual. We also see limited utility in the increasingly popular cognitive and constructivist models that ultimately define humans as simple information-processing machines as opposed to meaning-generating beings (Anderson and Goolishian, 1988, 1990a; Goolishian and Anderson, 1981).

Meanwhile, our developing theories of therapy are rapidly moving toward a more hermeneutic and interpretive position. This is a view that emphasizes 'meanings' as created and experienced by individuals in conversation with one another. In pursuit of this new theoretical base, we have developed a number of ideas that move our understanding and explanations of therapy into the arena of shifting systems that exist only in the vagaries of discourse, language and conversation. It is a position that is nested in the domains of semantics and narrative. Our current position leans heavily on the view that human action takes place in a reality of understanding that is created through social construction and dialogue (Anderson and Goolishian, 1985; Anderson et al., 1986a; Anderson and Goolishian, 1988). From this position, people live, and understand their living, through socially constructed narrative realities that give meaning and organization to their experience. It is a world of human language and discourse. Earlier, we have talked about these ideas, about systems of meaning, under the rubric of problem-determined systems, problem-organizing dis-

solving systems, and language systems (Anderson and Goolishian, 1985; Anderson et al., 1986a, b; Anderson and Goolishian, 1988; Goolishian and Anderson, 1987).

Our current narrative position leans heavily on the following premises (Anderson and Goolishian, 1988; Goolishian and Anderson, 1990).

First, human systems are language-generating and, simultaneously, meaning-generating systems. Communication and discourse define social organization. A socio-cultural system is the product of social communication, rather than communication being a product of structural organization. All human systems are linguistic systems and are best described by those participating in it, rather than by outside 'objective' observers. *The therapeutic system is such a linguistic system.*

Secondly, meaning and understanding are socially constructed. We do not arrive at, or have, meaning and understanding until we take communicative action; that is, engage in some meaning-generating discourse or dialogue within the system for which the communication has relevance. *A therapeutic system is a system for which the communication has a relevance specific to its dialogical exchange.*

Thirdly, any system in therapy is one that has dialogically coalesced around some 'problem.' This system will be engaged in evolving language and meaning specific to itself, specific to its organizations and specific to its dis-solution around 'the problem.' In this sense, the therapy system is a system that is distinguished by the evolving co-created meaning, 'the problem,' rather than an arbitrary social structure, such as a family. *The therapeutic system is a problem-organizing, problem-dis-solving system.*

Fourthly, therapy is a linguistic event that takes place in what we call a therapeutic conversation. The therapeutic conversation is a mutual search and exploration through dialogue, a two-way exchange, a criss-crossing of ideas in which new meanings are continually evolving toward the 'dis-solving' of problems, and thus, the dissolving of the therapy system and hence the *problem-organizing problem-dis-solving system.*

Fifthly, the role of the therapist is that of a conversational artist – an architect of the dialogical process – whose expertise is in the arena of creating a space for and facilitating a dialogical conversation. *The therapist is a participant-observer and a participant-facilitator of the therapeutic conversation.*

Sixthly, the therapist exercises this therapeutic art through the use of conversational or therapeutic questions. The therapeutic question is the primary instrument to facilitate the development of

conversational space and the dialogical process. To accomplish this *the therapist exercises an expertise in asking questions from a position of 'not-knowing' rather than asking questions that are informed by method and that demand specific answers.*

Seventhly, problems we deal with in therapy are actions that express our human narratives in such a way that they diminish our sense of agency and personal liberation. Problems are concerned or alarmed objection to a state of affairs for which we are unable to define competent action (agency) for ourselves. In this sense, *problems exist in language and problems are unique to the narrative context from which they derive their meaning.*

Eighthly, change in therapy is the dialogical creation of new narrative, and therefore the opening of opportunity for new agency. The transformational power of narrative rests in its capacity to re-relate the events of our lives in the context of new and different meaning. *We live in and through the narrative identities that we develop in conversation with one another.* The skill of the therapist is the expertise to participate in this process. Our 'self' is always changing.

These premises place heavy emphasis on the role of language, conversation, self, and story as they influence our clinical theory and work. Today there is much interest among therapists about these issues in the continuing attempts to understand and describe clinical work. There are, however, very different views emerging. Some writers emphasize the stability over time of the personal narratives that we work with in therapy. We, on the other hand, emphasize the always changing, evolving, and dialogical basis of the story of the self. In taking this position, we find ourselves emphasizing the therapist position of *not-knowing* in the understanding that develops through therapeutic conversation. The concept of not-knowing is in contrast to therapist understanding that is based in pre-held theoretical narratives.

Not-knowing requires that our understandings, explanations, and interpretations in therapy not be limited by prior experiences or theoretically formed truths, and knowledge. This description of the not-knowing position is influenced by hermeneutic and interpretive theories and the related concepts of social constructionism, language, and narrative (Gergen, 1982; Shapiro and Sica, 1984; Shotter and Gergen, 1989; Wachterhauser, 1986). This hermeneutic position represents the theory and practice of interpretation. Fundamentally, it is a philosophical stance that 'maintains that understanding is always interpretive . . . that there is no privileged standpoint for understanding' (Wachterhauser, 1986: 399) and that 'language and history are always both conditions and limits to

understanding' (Wachterhauser, 1986: 6). Meaning and understanding are socially constructed by persons in conversation, in language with one another. Thus, human action takes place in a reality of understanding that is created through social construction and dialogue. These socially constructed narrative realities give meaning and organization to one's experience (Gergen, 1982; Shotter and Gergen, 1989; Anderson and Goolishian, 1988).

Therapeutic Conversation: a Dialogical Mode

The process of therapy based on this stance, on this dialogical view, is what we call a therapeutic conversation. Therapeutic conversation refers to an endeavor in which there is a mutual search for understanding and exploration through dialogue of 'problems.' Therapy, and hence the therapeutic conversation, entails an 'in there together' process. People talk 'with' one another and not 'to' one another. It is a mechanism through which the therapist and the client participate in the co-development of new meanings, new realities, and new narratives. The therapist's role, expertise, and emphasis is to develop a free conversational space and to facilitate an emerging dialogical process in which this 'newness' can occur. The emphasis is not to produce change but to open space for conversation. In this hermeneutic view, change in therapy is represented by the dialogical creation of new narrative. As dialogue evolves, new narrative, the 'not-yet-said' stories, are mutually created (Anderson and Goolishian, 1988). Change in story and self-narrative is an inherent consequence of dialogue.

Achieving this special kind of therapeutic conversation requires that the therapist adopt a *not-knowing* position. The not-knowing position entails a general attitude or stance in which the therapist's actions communicate an abundant, genuine curiosity. That is, the therapist's actions and attitudes express a need to know more about what has been said, rather than convey preconceived opinions and expectations about the client, the problem, or what must be changed. The therapist, therefore, positions himself or herself in such a way as always to be in the state of 'being informed' by the client ('client' in this chapter refers to one or more persons). This 'being informed' position is critical to the assumption in hermeneutic theory that the dialogical creation of meaning is always a continuing process. In not-knowing the therapist adopts an interpretive stance that relies on the continuing analysis of experience as it is occurring in context.

The therapist does not 'know,' a priori, the intent of any action, but rather must rely on the explanation made by the client. By

learning, by curiosity, and by taking the client's story seriously, the therapist joins with the client in a mutual exploration of the client's understanding and experience. Thus the process of interpretation, the struggle to understand in therapy, becomes collaborative. Such a position allows the therapist always to maintain continuity with the client's position and to grant primary importance to the client's world views, meanings, and understandings. This allows clients room for conversational movement and space, since they no longer have to promote, protect, or convince the therapist of their view. This relaxing, this releasing process, is similar to a notion attributed to Bateson: specifically, in order to entertain new or novel ideas, there has to be room for the familiar. This does not mean that the therapist develops and offers the new ideas or the new meanings. They emerge from the dialogue between the therapist and the client and thus are co-created. The therapist simply becomes part of the circle of meaning or hermeneutic circle (for discussions of the circle of meaning or the hermeneutic circle, see Wachterhauser, 1986: 23-4; Warnke, 1987: 83-7).

In therapy, the hermeneutic circle, or circle of meaning, refers to the dialogical process through which interpretation begins with the therapist's preconceptions. The therapist always enters the therapeutic arena with expectations about the issues to be discussed that are based on the therapist's prior experiences and the referral information. Therapy always begins with a question based on this already created meaning. The meaning that emerges in therapy is understood from this whole (the therapist's preconceptions), but this whole is, in turn, understood from the emerging parts (the client's story). Therapist and client move back and forth within this circle of meaning. They move from part to whole to part again, thus remaining within the circle. In this process, new meaning emerges for both therapist and client.

To 'not-know' is *not* to have an unfounded or unexperienced judgment, but refers more widely to the set of assumptions, the meanings, that the therapist brings to the clinical interview. The excitement for the therapist is in learning the uniqueness of each individual client's narrative truth; the coherent truths in their storied lives. This means that therapists are always prejudiced by their experience, but that they must listen in such a way that their pre-experience does not close them to the full meaning of the client's descriptions of their experience. This can only happen if the therapist approaches each clinical experience from the position of not-knowing. To do otherwise is to search for regularities and common meaning that may validate the therapist's theory but invalidate the uniqueness of the clients' stories and thus their very identity.

The development of new meaning relies on the novelty and the newness, the not-knowing of what it is that the therapist is about to hear. This requires that the therapist have a high capacity simultaneously to attend to both inner and outer conversation. Gadamer has stated:

A person trying to understand a text is prepared for it to tell him something. That is why a hermeneutically trained mind must be, from the start, sensitive to the text's quality of newness. But this kind of sensitivity involves neither 'neutrality' in the matter of the object nor the extinction of one's self, but the conscious assimilation of one's own bias, so that the text may present itself in all its newness and thus be able to assert its own truth against one's foremeanings. (1975: 238)

Interpreting and understanding, then, is always a dialogue between therapist and client and is not the result of predetermined, theoretical narratives that are essential elements of the therapist's world of meaning.

Central to the many linguistic and socially derived narratives that operate in behavioral organization are those that contain within them the elements articulated as self-descriptions, or first-person narratives. The development of these self-defining narratives takes place in a social and local context involving conversation with significant others, including oneself. That is, people live in and through the ever-changing narrative identities that they develop in conversation with one another. Individuals derive their sense of social agency for action from these dialogically derived narratives. Narratives permit (or inhibit) a personal perception of freedom or competency to make sense and to act (agency). The 'problems' dealt with in therapy can be thought of as emanating from social narratives and self-definitions that do not yield an agency that is effective for the tasks implicit in their self-narratives. Therapy provides opportunity for the development of new and different narratives that permit an expanded range of alternative agency for 'problem' dis-solution. It is the accomplishment of this new narrative agency that is experienced as 'freedom' and liberation by those who view therapy as successful.

At the same time this liberation requires a shift away from the traditional concept of therapist-client separation. We view client and therapist as being together in a system that evolves over the course of the therapeutic conversation. Meaning becomes a function of their relationship. From this perspective, client and therapist are seen as mutually affecting each other's meaning, and meaning becomes a byproduct of mutuality. Client and therapist are dependent in the moment-to-moment creation of new understandings. In effect, they generate a dialogically shared meaning

that exists only at the moment in the therapeutic conversation which continues to change throughout time.

Conversational Questions: Keeping Understanding on the Way

Traditionally, questions in therapy are influenced by the therapist's expertise, an expertise reflective of a theoretical understanding and knowledge of psychological phenomenon and human behavior. That is, the therapist explains (diagnoses) and intervenes (treats) the phenomenon or behavior from this prior knowledge base, from generalized theory. In doing this therapists emphasize (and protect) their own narrative coherence rather than the client's. This knowing position is similar to what Bruner (1984) distinguishes as a 'paradigmatic posture' versus a 'narrative posture.' In the paradigmatic posture the interpreter focuses on explanation that emphasizes a denotative understanding, general categories, and broader rules. For example, the use of concepts such as 'id,' 'super ego,' or 'symptom functionality' are the type of broad categories often developed in the process of therapeutic understanding. To ask questions in therapy from a knowing position fits with Bruner's paradigmatic posture in that the response is limited to the therapist's pre-held theoretical perspective. In contrast, the not-knowing position – similar to Bruner's 'narrative posture' – suggests a different kind of expertise; one that is limited to the process of therapy rather than to the content (diagnosis) and change (treatment) of pathological structure.

The therapeutic or conversational question is the primary tool that the therapist uses to express this expertise. It is the means through which the therapist remains on the road to understanding. Therapeutic questions always stem from a need to know more about what has just been said. Thus, the therapist is always being informed by the client's stories and is always learning new language and new narrative. Questions that are overly directed by a methodology risk squelching the therapist's opportunity to be led by the clients into their own worlds. The basis of therapeutic questioning is not simply to interrogate the client or to gather information for validating or supporting hypotheses. Rather, the aim is to allow the client to lead the therapist's own range of understanding into question.

In this hermeneutic sense, during the process of psychotherapy, the therapist is not applying a method of questioning but rather is continually adjusting his or her understanding to that of the other person. Thus, the therapist is always in the process of

understanding, always on the way to understanding and always changing. Not-knowing questions reflect this therapist position and this therapeutic process. Thus, the therapist does not dominate the client with expert psychological knowledge so much as he or she is led by, and learns from, the expertise of the client. The therapist's task, therefore, is not to analyze but to attempt to understand, to understand from the changing perspective of the client's life experience. The object in hermeneutic understanding is to let the phenomena lead. Bill's words at the beginning of this chapter seem indeed a lament for just this sort of understanding.

Local Meaning and Local Dialogue

The process of questions generated from the position of 'not-knowing' results in the development of a locally (dialogically) constructed understanding and a local (dialogic) vocabulary. Local refers to the language, the meaning, and the understanding developed between persons in dialogue, rather than broadly held cultural sensibilities. It is through local understanding that one makes intimate sense out of memories, perceptions, and histories. Through this process the space for continuing new narrative with new history – and thus new future – remains open.

The issue of local meaning and local language is important because it seems that there is a range of experiences and a way of knowing these experiences that is sufficiently different from 'knower' to 'knower' which will vary from therapy to therapy. Garfinkel (1967) and Shotter (1990) make the strong point that in any conversation the participants will refuse to understand what is being said other than within the meaning rules which have been negotiated within the context of the immediate dialogical exchange itself. Meaning and understanding is, according to Garfinkel, always a matter of negotiation between the participants. The traditional paradigmatic language of general psychological and family theory can never be sufficient to explain or understand locally derived meaning. To attempt to understand the first-person experiences that therapists deal with in therapy through the use of general psychological and family models as well as the associated vocabularies leads to a reduction to stereotypical, theoretical concepts. In using such concepts, such pre-knowledge, to understand the client's narrative, therapists often lose touch with the client's locally developed meanings and can constrain the client's narrative. The therapist, therefore, becomes an expert in asking questions about the stories told in therapy in a way that the questions relate to the reasons for consultation (for example, the

problem as reported). To do this requires that the therapist remain attentive to the development of, and understand within the client's language, the narrative and the metaphors that are specific to the problem.

What Therapeutic Questions are *Not*

Therapeutic questions from a not-knowing position are in many ways similar to so-called Socratic questions. They are not rhetorical or pedagogical questions. Rhetorical questions give their own answers; pedagogical questions imply the direction of the answer. Questions in traditional therapy are often of this nature; that is, they imply direction (correct reality), and leave the client a hint in order to reach the 'correct' answer.

In contrast, not-knowing questions bring into the open something unknown and unforeseen to the realm of possibility. Therapeutic questions are impelled by difference in understanding and are drawn from the future by the as-yet unrealized possibility of a community of knowledge. In asking from this position the therapist is able to move with the 'not-yet-said' (Anderson and Goolishian, 1988). Therapeutic questions also imply many possible answers. Conversation in therapy is the unfolding of these 'yet-unsaid' possibilities, these 'yet-unsaid' narratives. This process accelerates the evolution of new personal realities and agency that emerge from the evolving of new narratives. New meaning, and therefore new agency, is experienced as change in individual and social organization.

A Case Example: 'How long have you had this disease?'

A frustrated psychiatric colleague requested a consultation on an impenetrable case – a forty-year-old man who chronically felt he had a contagious disease and was perpetually infecting others, even killing them, with it. Multiple negative medical consultations and psychotherapies had failed to relieve the man of his conviction and fear about his infectious disease. Although he talked of difficulties in his marriage (his wife didn't understand him) and his inability to work, his primary concern was his disease and the ever-spreading contamination. He was frightened, distraught, and unable to be at peace because of the harm and destruction that he knew he was spreading.

Early in his story, wringing his hands, he told about being diseased and infectious. The consultant (Goolishian) asked him, 'How long have you had this disease?' Looking astonished and

after a long pause, the man began to tell his story. It began, he said, when he was a young merchant seaman. While in the Far East he had sexual contact with a prostitute. Afterwards, remembering the lectures on sexually transmitted diseases that were given to the crewmen on the boat, he feared that his lust had exposed him to one of these horrible sexual diseases and that he required treatment. Panicked, he went to a local clinic for consultation. At this clinic, he explained his fears to a nurse who was from a religious order. She sent him away saying that they did not treat sexual perverts there – that he needed confession and God, not medicine. For a long time after that, ashamed and guilt-ridden, he kept his concerns to himself and confided in no one.

When he returned home from sea he was still frightened that he had contracted some disease but he could not bring himself to confide in anyone. He would appear at various medical clinics, ask for a physical examination and be told that he was in excellent shape. These negative reports convinced him that his disease was much worse because it was unknown to medical science. As his concerns grew he began to think that he was infectious and that he was contaminating others. This contamination of others became such a problem that he eventually realized that he was infecting others indirectly; for example, by viewing television or by listening on the radio. He continued to consult physicians, but the physical and laboratory examinations were always negative. By now he was being told, not only that he did *not* have a disease but that he *did* have a mental condition, and he was referred on several occasions for psychiatric consultation. Over time he became convinced that no one understood the seriousness of his contamination, the extent of his disease, nor the destruction he was causing.

As the consultant continued to show interest in his dilemma, the man became more relaxed. Somewhat animated, he elaborated his story and joined with the consultant's curiosity. The consultant did not simply take a history or re-collect events of the static past. His curiosity remained with the man's reality (the disease and contamination problem). The intent was not to challenge the man's reality or the man's story, but rather to learn about it, and to let it be re-told in a way that allowed the opportunity for new meaning and new narrative to emerge. In other words, the consultant's intent was not to talk or manipulate the man away from his ideas, but rather through not-knowing (non-negation and non-judgment) to provide a starting point for dialogue and the opening of conversational space.

Colleagues viewing the interview process were quite critical of this collaborative position and of questions like 'How long have

you had this disease?' They feared that such questions have the effect of reinforcing the patient's 'hypochondriacal delusion.' Many suggested that a safer question would have been, 'How long *have you thought* you had this disease?'

The not-knowing position, however, precludes the stance that the man's story was delusional. He said he was sick. Thus, it was necessary to hear more, to learn more about his sickness, and to converse within this languaged reality. Being sensitive to and trying to understand the man's reality was an essential step in a continuous process towards establishing and maintaining a dialogue. It was critical that the consultant remain within the rules of meaning as developed in the local conversation and to talk and understand in the familiar language and vocabulary of the client. This is not the same as condoning or reifying another's reality. It is a conversational moving within the 'sense' of what has just been said. It moves with the narrative truth of the client's story rather than challenging it, and remains within the locally developed and locally negotiated meaning system.

To have asked a safer question like 'How long is it that you *think* you have been diseased?' would only have served to impose the consultant's predetermined or 'knowing' and 'paradigmatic' view that the disease was a figment of the man's imagination or a delusion and distortion in need of correction. In response to such a question the suspicious man would have been left to operate from his own preconceived ideas and expectations of the consultant. Most likely, once again, he would have felt misunderstood and alienated. The consultant would have been just one more in the line-up of professionals who could not believe and who asked 'conditional' questions. Misunderstanding and alienation are ingredients that close rather than open dialogue.

Upon leaving this interview, the man was asked by the referring psychiatrist (who had been observing) how the interview went. His immediate response was, 'You know, he believed me!' In a follow-up conversation, the psychiatrist described the continuing effect that the interview had on himself and the client. He said that the therapy sessions seemed less difficult and that the man's life situation was much better. Somehow, he said, whether or not the man was infected was no longer an issue. The man was now dealing with his marriage and unemployment problems and there had even been some conjoint sessions with the man's wife. The consultant's not-knowing opened a starting point for, a possibility for, a dialogical exchange between the client and himself, between the client and the psychiatrist, and between the psychiatrist and himself.

such a way that the power of countless new possibilities is invoked, and thus new fiction and new history are created. Imagination is constituted in the inventive power of language through the active process of conversation; the searching for the 'not-yet-said.'

In therapy, interpretation, the struggle to understand, is always a dialogue between client and therapist. It is not the result of predetermined theoretical narratives essential to the therapist's world of meaning. In attempting to understand the client the assumption must be made that the client has something to say, and that this something makes narrative sense, asserts its own truth, within the context of the client's developing story. The therapist's response to the sense of the client's story and its elements is in contradiction to the traditional position in therapy which is to respond to the nonsense, or pathology, of what has been said. In this process the newly co-authored narrative understanding must be in the ordinary language of the client. A therapeutic conversation is no more than a slowly evolving and detailed, concrete, individual life story stimulated by the therapist's position of not-knowing and the therapist's curiosity to learn. It is this curiosity and not-knowing that opens conversational space and thus increases the potential for the narrative development of new agency and personal freedom.

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This does not suggest that the consultant's questions produced a miracle cure. Nor is it to suggest that any other question would force a further therapeutic impasse. No magical question or intervention can singularly influence the development of a life. No one question can open a dialogical space. Nor does the question itself cause someone to shift meaning, to have or not to have a new idea. But, rather, each question is an element of an overall process.

The therapist's central task is to find the question to which the immediate recounting of experience and narrative presents the answer. Such questions cannot be pre-planned or pre-known. What has just been told, what has just been recounted, is the answer to which the therapist must find the question. The developing therapeutic narrative is always presenting the therapist with the next question. From this perspective, questions in therapy are always driven by the immediate conversational event. To not-know means that the accumulated experience and understanding of the specific therapist is always undergoing interpretive change. It is in this local and continuing process of question and answer that a particular understanding or a particular narrative becomes a starting point for the new and 'not-yet-said.'

Summary

Therapeutic conversation and therapeutic questions that stem from the position of not-knowing become a collaborative effort of generating new meaning based on the linguistic and explanatory history of the client, as his or her story is continually retold and elaborated through the therapeutic dialogue. This kind of dialogical exchange facilitates the change in first-person narrative that is so necessary to change in therapy. New futures result from developing narratives that give new meanings and understandings to one's life and enable different agency. In therapy this is best accomplished by questions born of a genuine curiosity for that which is 'not-known' about that which has just been said.

Telling one's story is a re-presentation of experience; it is constructing history in the present. The re-presentation reflects the teller's re-description and re-explanation of the experience in response to what is not-known by the therapist. Each evolves together and influences the other, as well as the experience, and thus, the re-presentation of the experience. This does not mean that in the course of therapy therapists simply narrate what has already been known. They do not recover some identical picture or story. Rather, therapists explore the resources of the 'not-yet-said.' People have imaginative memory. Past accounts are retrieved in

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