

Sociopolitical Activist or Conversational Partner? Distinguishing the Position of the Therapist in Narrative and Collaborative Therapies

GERALD MONK, PH.D.
DIANE R. GEHART, PH.D.

In this article, we explore the similarities and differences of two contemporary family therapy approaches: narrative and collaborative therapies. These therapies are contrasted by describing positioning of the narrative practitioner as sociopolitical activist and the collaborative practitioner as conversational partner. The article begins with a brief overview of the two therapies. Subsequently we outline their epistemological genealogies and the practice similarities that arise from the theoretical assumptions underpinning these therapies. The remainder of the article addresses the theoretical and therapeutic differences in narrative and collaborative approaches reflected in the positioning of therapist as either sociopolitical activist or conversational partner. While narrative and collaborative approaches share more similarities than differences in relation to their emphasis on

the constitutive characteristics of language, focus on socio-relational contexts, and critique of singular objective truths, prominence is given to the starker contrasts in narrative and collaborative understandings of politics, power, dialogue, and discourse. It is proposed that by outlining some provocative contrasts between narrative and collaborative approaches, new conversations and generative practices will emerge in the therapy room.

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Over the past 2 decades, social constructionist ideas have had a significant effect on the development of family therapy. Emerging from a philosophical movement located in several key disciplines, including philosophy, anthropology, and sociology social constructionist theory emphasizes how language works and how meaning is created (Gergen, 1985; Shotter, 1989). Words are not thought of as having meaning in themselves, but rather they derive their meaning from the contexts in which they are produced or constructed. Furthermore, language is more than what is expressed or performed between speaker and hearer. It emerges from the cultural practices that give shape to human interaction. Therefore, from a social constructionist perspective, language constructs the means by which thoughts, feelings, and behaviors are

Gerald Monk, Department of Counseling and School Psychology, San Diego State University; Diane Gehart, Counseling and Special Education Department, California State University, Fresno.

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Correspondence regarding this article should be addressed to Gerald Monk, Ph.D., Department of Counseling and School Psychology, San Diego State University, 5500 Campanille Drive, San Diego California 92182-1179. E-mail: gmonk@mail.sdsu.edu

produced, and because it is historically and culturally located, it cannot be taken as once-and-for-all "truth" (Gergen, 1999).

Both narrative and collaborative approaches have much in common with a social constructionist epistemology. These epistemological similarities will be developed in more depth later in the article in addition to the distinctive characteristics that separate the two approaches. Our purpose in this article is to explore and reflect upon the similarities and differences between narrative and collaborative therapies, which are often confused or conflated (Minuchin, 1998, 1999). Our exploration of this difference is provocative as we seek to engender a thoughtful discussion between theorists and practitioners who wish to promote further evolution in these two contemporary therapies. Distinctions between these two therapies are drawn by describing the therapeutic position of the narrative therapist as sociopolitical activist and the therapeutic position of the collaborative therapist as conversational partner.

NARRATIVE AND COLLABORATIVE THERAPIES: A BRIEF OVERVIEW

Narrative Therapy

White and Epston (1990), central figures in the development of narrative therapy, drew upon three pivotal ideas which include: (a) mapping events through time is necessary in order to perceive difference and change (Bateson, 1972, 1980); (b) stories determine the meaning ascribed to experience (Bruner, 1986a, 1986b); and (c) deconstructing subjugating practices allows for new life forms (Foucault, 1972, 1979, 1980). First, White and Epston employed Bateson's "news of difference" concept which suggests that in order to detect and acquire new information, people engage in a process of comparison. White used this idea in the therapeutic domain in order to help clients draw distinctions between one set of experiences and another, thereby

generating new meanings of their problem circumstances. The resulting "news of difference" invokes a renewed sense of volition to address their circumstances in a way that was previously unimaginable.

White and Epston also harnessed Bruner's idea that narratives organize experience and generate meaning. In emphasizing the importance of how people story their experience and perform these stories in their lives, they maintained that stories were not only descriptive but also constitutive. Perhaps more influential within Bruner's work was the idea that because narratives do not encompass the full richness of our lives, there are numerous lived experiences that are not storied. Such untold stories inspired White and Epston's interest in unique outcomes.

Perhaps the most outstanding figure to have intimately affected narrative therapy is Michel Foucault. White has turned Foucault's intellectually obscure writings into a powerful resource for therapy (White, 1992). Foucault emphasized how personal narratives are subjugated by dominant discourse that maintains the status quo in relationships, families, and communities (Parry & Doan, 1994). The status quo in communities produces normalizing practices that constrain and undermine people's efforts to lead a life of their own design. White developed strategies that assisted people to gain access to story lines previously subjugated by the family's and culture's dominant discourses as to what is expected (Parry & Doan). In exposing the taken-for-granted "truths" that dictate how to live and behave, narrative therapists aim to liberate people from society's marginalizing practices that determine what is acceptable and unacceptable.

Collaborative Therapies

Many family therapists have contributed to the development of what can loosely be called the collaborative therapies (Andersen, 1990, 1991; Anderson & Goolishian, 1992;

Hoffman, 1993, 2001; Penn, 2001). These therapies share several common practices, most notably (a) an egalitarian, not-knowing stance; (b) the generation of multiple perspectives to create new meaning; and (c) non-interventionist intentions in therapy. Grounding themselves in the constructionist assumption that socially designated "experts" (i.e., therapists) do not possess inherently superior or "objective" knowledge, Anderson and Goolishian (1992) built upon family therapy's long and intimate association with cultural anthropology (Bateson, 1972), which foreshadowed the emphasis upon the curious posture of the therapist/anthropologist to learn more about the cultural meanings attached to human behavior. They were the first to specifically propose that therapists maintain a "not-knowing" stance in therapeutic interactions. From this stance, therapists were seen actively to invite clients' views and interpretations into the conversation to encourage a "democratic" (Andersen, 1995); two-way exchange of ideas and to expand possibilities. This collaborative, nonhierarchical stance is perhaps the most distinctive and significant contribution of the collaborative therapies to the field and has been espoused and cited by some narrative therapists (Freedman & Combs, 1996; Freeman, Epston, & Löbovits, 1997; Monk, Winslade, Crocket, & Epston, 1997).

Assuming this not-knowing stance, collaborative practitioners invite multiple, contradictory voices into therapeutic conversations, which allows participants to generate and explore new perspectives and meanings together. Anderson and Goolishian (1988) invite multiple voices into therapeutic conversations by including all persons in dialogue about the "problem" into the therapy process, thus creating a "problem-determined" system, a system that is organized around the linguistic identification of a "problem." As differing

understandings and perspectives about the problem are exchanged in a dialogical process that is not aimed at generating a single problem description, the participants' construction of the problem(s) shifts, allowing for new thoughts, emotions, and actions in relation to the problem. Through this ongoing process, the interpretation of the situation as a "problem" dissolves.

Other approaches to generating multiple perspectives include inviting reflecting teams to generate multiple perspectives about a client's situation (Andersen, 1991, 1995); attending to signs of people's "inner" talk to inform the direction, pace, and content of "outer" talk or therapy conversations (Andersen, 1991); using letter writing and multiple hypothetical descriptions to make room for silenced inner voices (Penn, 2001; Penn & Frankfurt, 1994; Penn & Sheinberg, 1991); and using "associative forms," such as stories, images, metaphors, and jokes, so that meanings do not become fixed (Hoffman, 1993).

Finally, practices employed by collaborative therapists, such as the ones above are not intended as "interventions" in the traditional sense that they should have a particular effect on clients. Instead, they are considered as possible practices or suggestions that may or may not be helpful to a particular client. For example, rather than expressing repressed emotions or documenting emerging narratives, Penn's letter writing invites different voices into the conversation with the expectation that each new voice offers another possibility for understanding.

SIMILAR EPISTEMOLOGICAL PREMISES *No Singular, Objective Truth*

Narrative and collaborative therapy approaches are grounded in similar social constructionist assumptions about reality and knowledge (Gergen, 1999). From a social constructionist perspective, reality is not singular, objective, or "out there," but rather it is something we produce and

something that can change as well (Monk et al., 1997). Both therapies emphasize the complexity and multiplicity in human functioning and suggest that one cannot obtain essential understandings about existence. Thus, social constructionist therapists seek to recognize the contextual and interpretive understandings within the therapeutic process.

Language as Formative

Another epistemological similarity is the social constructionist focus on language as a primary means of constructing meaning. Social constructionist epistemology emphasizes how human experience and action is always mediated by language. Language is considered an active relational process with real effects, rather than a passive, representational medium (Burr, 1995).

Social and Relational Contexts

Social constructionist therapists also maintain that problems are identified within sociocultural and relational contexts rather than existing within individuals. The therapeutic endeavor concentrates upon the socially constructed dialogue and the narrative accounts that clients present.

Relational Identity

Social constructionist therapists maintain that one's identity or personhood is developed, sustained, and transformed in and through relationships, both immediate and within the society at large (Gergen, 2001; McNamee & Gergen, 1999). This relational description of identity is distinct from the modernist emphasis on lone individuality and fixed personality structures.

PRACTICAL IMPLICATIONS OF EPISTEMOLOGICAL SIMILARITIES *Eschewing Models of Mental Health*

Their recognition of sociocultural contexts and language in generating problems invites narrative and collaborative therapists to

challenge traditional Western psychology, which defines adjustment in terms of dominant cultural values (Lyddon, 1995). Therefore, while traditional psychotherapy privileges Western, white, middle-class values as the "valid" means to mental health, social constructionist approaches recognize the potential negative effects of therapies that pathologize and categorize human beings when they do not conform to stereotypical health standards (Drewery, Winslade, & Monk, 2000; Gergen, 1994). Instead, they hold knowledge tentatively and assist people to identify resources to attain preferred outcomes.

Nonexpert Stance

Consistent with their opposition to models of health, both approaches employ a non-expert stance in relation to clients. Social constructionist therapists seek to understand clients' lived experience and avoid efforts to predict, interpret, or pathologize (Anderson & Goolishian, 1992; White & Epston, 1990). Within this process, both narrative and collaborative therapists claim a non-expert approach to their work and are committed to collaborating with clients to assist them to experience a heightened sense of agency.

Reflecting Teams

Both narrative and collaborative therapists employ reflecting teams, first introduced by Andersen (1991) to bring multiple voices into the therapy process. The major task of reflecting teams is to bring a community of persons into the relationship with clients as a means of generating multiple perspectives.

EPISTEMOLOGICAL DISTINCTIONS

We argue that while both therapies share numerous similarities, they differ in their views of appropriate therapist positioning. Kogan and Gale (1997) have described the function of the narrative therapist, using White and Epston's (1990) phrase, as

"liberating subjugated knowledges and life stories" (p. 102) Relatedly, we propose that the function and position of the narrative therapist is one of "sociopolitical activist" since this depiction describes the political interventionist applications of narrative therapy practitioners who address more directly the impact of historical and cultural factors on problem experiences (Monk & Sinclair, 2001). The term sociopolitical activist is also based upon narrative literature that emphasizes the political nature of therapy, cautions therapists to avoid oppressive behaviors, and encourages a political stand against oppression (White & Epston, 1990).

Previously, Anderson and Goolishian (1988) have referred to the role of the therapist using a collaborative approach as a master conversationalist. We wish to use Anderson's (1997) more contemporary description of collaborative therapists as "conversational partners." Conversational partner places more emphasis on issues being linguistically constructed in the here and now with less emphasis or relevance placed upon history, tradition and culture not directly featured in the therapeutic conversation. Using these metaphors illustrates epistemological divergences and disparate practical applications between the two approaches as the narrative therapist's focus remains on countering oppressive practices and the collaborative therapist's interest focuses on encouraging multiplicity of possibilities. It must be pointed out that while we describe the positions that narrative and collaborative practitioners may assume with their clients, there is no guarantee that these positions are necessarily performed by the practitioners concerned. For example, because a narrative therapist might suggest he or she is championing social justice, fighting against oppression, and otherwise working progressively, this does not mean that these intentions and purposes are experienced in these terms by clients.

SOCIOPOLITICAL ACTIVIST: EPISTEMOLOGICAL FOUNDATIONS *Foucault and Knowledge/Power*

While most narrative therapists locate themselves within a social constructionist metaphor (Freedman & Combs, 1996), their version of constructionism is heavily influenced by Foucault. Foucault described how a society's dominant discourses marginalize some groups and empower others. White and Epston (1990), drawing heavily on Foucault's political analysis, noted how *stories* carry discourses, supporting certain voices and silencing others. Dominant cultural ideas embedded in stories become the norms that determine what society values and devalues and inform the stories individuals tell about themselves. The influence of the dominant cultural ideas or narratives imparted by society provides the resources for interpreting one's experience as "good" or "bad," "problematic" or "normal." Thus, narrative approaches distinguish themselves from collaborative approaches by focusing on problem stories that dominate and subjugate at both social and personal levels.

Politics

Narrative therapists consider problems through a political lens, whether an overt cultural problem such as racism or a more covert pressure such as "healthy" relationships. This sociopolitical conceptualization of problems invites the exploration of cultural practices that produce dominant, oppressive narratives. Accordingly, narrative therapists "deconstruct" or "unpack" the cultural assumptions that contextualize client problems to demonstrate the effects of oppressive social practices on their clients. There are many practitioners who assume a sociopolitical activist position who are loosely associated with the narrative community. Many are committed to challenging certain dominant discourses that attempt to define and regulate people,

and many are motivated to stop oppressive practices and address their causes (Payne, 2000). Toward this end, White and Epston take political action in and outside of therapy, such as helping aboriginal peoples address social injustices, and supporting women by confronting patriarchy.

Tamasese and Waldegrave (1996) are examples of narrative-inspired therapists who have participated in a long campaign to address the structural and systemic, economic inequalities that have jeopardized the wellbeing of many Polynesian communities in New Zealand and the Pacific Rim. White (1997) encourages therapists to remain mindful of political issues and cautions against participating in marginalizing practices that may subtly creep into therapy because of personal histories. By drawing on the political agenda intrinsic to deconstruction, narrative therapists are positioned to counter oppression and advocate for socially just outcomes for their clients.

CONVERSATIONAL PARTNER:
EPISTEMOLOGICAL FOUNDATIONS
Dialogical Processes

Grounding themselves primarily in social constructionism (Gergen, 1999), collaborative therapists focus on meaning construction in the local dialogic encounter rather than drawing out the effects of dominant societal narratives. Early in their work, Anderson and Goolishian noted, "rather than learning a family's language, we were learning the particular language of each member of a family system" (Anderson, 1997, p. 61). Their emphasis is on constructing meaning between individuals in local conversations: "Each problem is conceived as a unique set of events or experiences that has meaning only in the context of the social exchange in which it happened" (p. 74). In practice, this view has translated into a focus on transforming meaning in the local therapeutic dialogue with less systematic

attention to the wider sociopolitical climate. For example, a couple wanting to work through a husband's past affair would not be directed to examine common societal biases but rather each spouse would be invited to share his or her perspective, which may or may not be consistent with dominant social values.

Differing Understandings about the Role of Discourse

Although they may be described as constructing meaning at the local level, collaborative therapists do not altogether neglect the broader social discourses highlighted in narrative therapy. However, collaborative therapists approach dominant discourses differently: "a problem and the meaning we attribute to it are no more than a socially-created reality that is sustained by behavior mutually coordinated in language" (p.73). Collaborative therapists view dominant discourses as a thread in local dialogue that may or may not have a significant impact on a particular individual's experience. Therefore, meaning construction can be viewed as an ongoing dialectic between societal and local understandings where societal understandings always have a unique local interpretation, which is in turn reshaped by broader discourse. For example, when working with a Mexican-American woman, the collaborative therapist does not necessarily consider that her ethnic or gender identity will be relevant to the therapy process. Instead, when these issues emerge as significant in the therapeutic dialogue for one of the participants (which may be the therapist), the therapist explores how the implicit and explicit dialogues between her, her family, friends, social network, community, and the media have defined and shaped her interpretation of her identity and/or the problem. The therapeutic dialogue creates another opportunity to reshape her understanding of her identity and situation.

In contrast, narrative therapists view dominant societal discourses as operating in systematic and influential ways at the local level and have ongoing real effects in how individual experiences their identity and relationships with others (Fairclough, 1992; Van Dijk, 1993; Wetherell & Potter, 1992). For example, narrative therapists typically explore the workings of power and influence of dominant discourses by capturing the dynamics of the discourse within therapeutic questions like the following: "You say you've been grieving since your son has told you he is homosexual. I'd find it really interesting if we could talk about the use of that word 'grieving' in this situation—would that be ok?" (Payne, 2000). Embodied in this question is the drawing attention to the client about issues of homophobia implicit in the client's comment about grieving. In another question, the client is addressing discourses associated with authoritarianism in parenting styles: "Where does your idea come from that to be a good father you must be very strict with your children?"

SOCIOPOLITICAL ACTIVIST: IMPLICATIONS FOR PRACTICE

A sociopolitical stance focuses therapists on countering oppression, encountered directly in society or indirectly through the dominant stories we adopt. This focus requires intentional intervention with clients to uncover and deconstruct the sources of oppression. Two techniques best illustrate sociopolitical intervention in narrative therapy: externalizing conversation and deconstructive questioning.

Externalizing

Perhaps narrative therapy's most distinctive feature, externalizing conversation, creates space between clients and problems to counteract oppressive, problem-saturated stories, thereby altering clients' relations to problems. Externalizing requires therapists to identify oppressive problem discourses and their effects on clients, and allows

clients to locate problem stories within a community's dominant discourses rather than within themselves. Although externalizing descriptions are typically developed in consultation with clients, narrative practitioners actively contribute by identifying externalizing descriptions that fit with the problem's central themes and the wider sociopolitical milieu.

Some writers such as Kottler (J. Kottler, personal communication, October 1996), however, have been concerned that externalizing conversation has the potential to diminish the degree of responsibility that people will have in taking charge of their lives. In addition, there have been concerns that this alternative language construction will provide excuses about why people should not change or why they should continue to blame others. This is particularly the case when therapists attempt to externalize the actions of people who have been violent to others or are quick to blame others for their abusive behavior. Because clients are viewed as agents in their life narratives from the outset, the tenor of the therapeutic conversation is focused on eliciting lived experiences that can be marshaled together to dispel what has now been constructed as an identifiable target. When people gain a full experience of the toll that damaging cultural prescriptions have exacted, including the effects of their abusive and violent behavior, narrative therapists would argue that there is often a heightened degree of motivation in the hurtful person to address their violent and abusive behavior.

Thus, externalization helps position therapists as sociopolitical activists who intervene against oppression. For example, Payne (2000) exemplifies this sociopolitical stance in his commitment to assist violent men to "take responsibility for the abuse, recognize its consequences, apologize, commit to change and confront patriarchal ideas so that their whole way of thinking [is] left behind" (p. 67)

Deconstructive Questioning

Narrative therapists take a deconstructive approach to make visible the effects of dominant discourses. Their motive is largely political and designed to produce a sense of agency to act against oppression. Deconstruction involves challenging taken-for-granted assumptions about life events, which requires therapists to draw upon their own political and moral positions. For example, Harker (1997) demonstrates this sociopolitical position by deconstructing the cultural idea that people should be either homosexual or heterosexual with the question: What difference might it make if we saw sexuality more as a continuum than a set of rigid categories? (p. 207). The question's language reveals the therapist's alternative construction of sexual identity.

CONVERSATIONAL PARTNER: IMPLICATIONS FOR PRACTICE

Anderson (1997) conceptualizes the therapist's role as that of a "conversational partner" and "facilitator of dialogue," rejecting the "narrative editor" analogy. Although some may argue it is impossible to entirely negate hierarchy in the therapeutic relationship, taking the position of a conversational partner demands that the therapist consciously strive to allow each person equal voice and space in the dialogue, which often requires suspending the therapist's professional and personal knowledge long enough to hear that of others. The therapist's focus is to invite clients into a dialogical partnership that uses multiple descriptions to generate new meanings and options regarding problems. Facilitating this partnership, rather than challenging oppressive discourses, is the therapist's primary focus. The goals of this partnership are set in concert by client and therapist and generally are aimed at dissolving/resolving a problem; however, the therapist's primary commitment is to facilitating a dialogical process rather

than to achieving a specifically agreed-upon end, based on the premise that goals are likely to be renegotiated over the course of therapy

Not Knowing

The collaborative therapist's not-knowing stance is primarily a way of being in relationship. Within this stance, therapists do not maintain commitments to any particular outcome or agenda other than that which has been jointly determined with the client. This liberation from a predetermined professional agenda to achieve a specific end (i.e., reduce the effects of oppressive discourse or reduce psychiatric distress) facilitates the collaborative construction of new interpretations and requires therapists themselves to evolve and change through the dialogue. Any comments, questions, or activities proposed by the therapist evolve naturally from the immediate conversational context. As Anderson and Goolishian (1992) assert, "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" (p. 33). This process of striving to understand creates space for the many-voices within and without to be heard, thus creating new perspectives and openings in relation to the problem. For example, when a client states that he feels "depressed," the therapist refrains from making assumptions based on professional or personal knowledge and instead explores how the client experiences and constructs this experience. If the client were to describe depression as a "cloud" over his life, the therapist would then explore the client's lived experience of the cloud and possibly its origin and effects.

Dialogical Conversation

Given this not-knowing stance, the collaborative therapist's basic task is to facilitate a dialogical conversation in which participants "take in" and "hear" the other.

Rather than attempting to intervene by using externalizing or other techniques, the therapist invites clients into dialogue and relies on the dialogical process to explore different voices and conversational streams that arise in different relationships and situations. The pacing of dialogical conversation is often slower than other conversations in order to allow space and time for inner dialogues to form and reform. Through the subtle shifts of inner and outer dialogue, each person's perspective and experience of the problem shifts. For example, when a family's dialogue is opened or slowed to allow for all members to hear the parent's inner dialogue of trying to love and protect as well as the adolescent's inner dialogue of needing to "discover himself," family members will construct their situations differently. Sometimes, it only takes one conversation for thoughts, feelings, and actions around the problem to shift; sometimes it takes a series of conversations. However, collaborative therapists place their confidence in the dialogical process to shift these realities and dissolve the experience of a "problem."

FINDING DISTINCTIONS IN CRITIQUES

The differences between the therapist's stance as a conversational partner or social-political activist can be marked. The activist stance demands direct intervention when the therapist observes oppressive practices and social inequities. For example, Kogan and Gale's (1997) discourse analysis of a narrative therapy session of Michael White's, illustrated clearly the interventionist position taken in the interview in assisting a male client address gender inequalities in his marital relationship. White presents his challenge to the client within a culturally gendered discourse and is motivated by a politically active agenda to address hierarchical power relations in the session. In contrast, the therapist, as conversational partner, consciously avoids intervening or directing

the content of the conversation (Anderson, 1997). Instead, the collaborative therapist relies on the multiple perspectives of persons in dialogue about the problem to raise such issues. Therefore, if the wife, family, friends, and social/ethnic/cultural group of the husband in the above example do not experience his construction of male identity as a part of the problem, the therapist would not be likely to raise the issue. However, Anderson (1997) asserts that when the therapist's own internal dialogue becomes focused on a particular thought or observation that the client has not raised, the therapist may tentatively offer the observation as part of the conversation.

Thus, one's stance determines which topics are addressed, and shapes how they are addressed. This difference is exemplified in a case involving domestic violence. From a narrative perspective, ending the oppression and violence would be a presumed goal. However, a collaborative therapist would be more likely to inquire about the meaning that the violence holds for the couple and proceed slowly until a mutual goal could be agreed upon by therapist and clients. The movement, pace, and direction of therapy would be noticeably different based on each therapist's relational stance.

In addition to distinctions in theory and practice, narrative and collaborative therapies can be differentiated by the concerns identified with each approach. For example, one of the purposes of storying clients' experience in narrative therapy is to help them mobilize their resources and remain vibrant and strong so as not to succumb to a long history of injustice undermining their energies and preferred self-descriptions. The processes of deconstruction and externalization invite a stable hero or heroine-like character to emerge in a client's preferred storyline, replacing an oppressed and downtrodden character (C. Smith, personal communication, January

30, 2002). However, some collaborative therapists perceive this as producing a mono-heroic story that leaves clients with less mobility and flexibility about how to relate to life's complex circumstances. Furthermore, externalizing typically involves metaphors of oppression and conflict, which further constrict the options available for addressing client concerns. Collaborative therapists argue that within a complex world, multiple voices and dialogic understandings help clients experience fluidity and responsiveness to their multifaceted relationships and realities; they contrast these dialogic understandings to the mono-heroic descriptions of overcoming oppression, which potentially offer possibilities that are more limited.

One of the critiques targeted at collaborative therapists is that while they state that they have no particular commitment to a therapeutic direction or intentional agenda, their practice in fact is both deliberate and purposeful. To the extent that collaborative therapists position themselves in a social constructionist epistemology and are dedicated to facilitating the production of multiple voices, they are inevitably motivated to follow one direction more than another in the therapeutic process. From some narrative therapists' points of view, the conversational partner is neither unintentional nor without purpose. Narrative therapists as social activists are also concerned by collaborative therapists' disinterest in acknowledging the sociopolitical discourses that impact and may systematically oppress individuals. Some are concerned that this disinterest invites the potential for therapists to collude with oppressive cultural practices. That is, at best, it restricts the therapist's option to assist the client, and at worst, it adds to the client's oppression. Collaborative therapists respond that, on the contrary, narrative therapists' directive approach and the sociopolitical stance that underpins it may inadvertently push clients toward "alternative stories" that clients feel

compelled to agree with, thus potentially producing another form of oppression (C. Smith, personal communication, January 30, 2002). Perhaps these distinctions can provide a note of caution to those narrative therapists who become too pushy pursuing a storyline that is deemed "preferred," while at the same time notifying collaborative therapists to be sensitive to not collude with culturally oppressive practices.

CONCLUDING THOUGHTS

While we have drawn distinctions between narrative and collaborative theory and practice, we wish to reassert that these social constructionist approaches continue to share more similarities than differences when compared with other traditions. They reject the notion of singular, objective "truth," recognize the constitutive characteristics of language, and emphasize relational identity and sociorelational contexts. In fact, there has been significant conversation between the two approaches that has resulted in the cross-fertilization of ideas (Freedman & Combs, 1996; Lyle & Gehart, 2000; Smith, 1995, 1997).

Despite the convergence, we have found value in wrestling with the distinct epistemological impulses and practice traditions. We believe that these differences are most clearly expressed in the positioning of the therapist, which we have explored using the starkest distinctions. By using such metaphorical descriptions, we inevitably exaggerate and to some extent reify the distinctions. Yet we also dare to articulate, shape, and add form to these therapeutic movements that have been reluctant to define themselves because they fear doing so will thwart the creative impulses that have been so significant to their success. Through our epistemological lens, we "freeze-frame" these therapies in this moment so that in the next moment, further generative moves and inspirational energies might be unleashed for the sake of "better practices" in the therapy room.

REFERENCES

- Andersen, T. (1990). *The reflecting team: Dialogues and dialogues about dialogues*. Broadstairs, Kent, UK: Borgman.
- Andersen, T. (1991). *Relationship, language, and preunderstanding in the reflecting process*. Paper presented at the Houston Galveston Narrative and Psychotherapy Conference, New Directions in Psychotherapy, Houston, Texas.
- Andersen, T. (1995). Reflecting processes; acts of informing and forming: You can borrow my eyes, but you must not take them away from me! In S. Friedman (Ed.), *The reflecting team in action: Collaborative practice in family therapy* (pp.11-37). New York: Guilford Press.
- Anderson, H. (1997). *Conversations, language, and possibilities: A postmodern approach to therapy*. New York: Basic Books.
- Anderson, H., & Goolishian, H. A. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process*, 27(4), 371-393.
- Anderson, H., & Goolishian, H. A. (1992). The client is the expert: A not-knowing approach to therapy. In S. McNamee & K. Gergen (Eds.), *Social construction and the therapeutic process* (pp. 25-39). Newbury Park, CA: Sage Publications.
- Bateson, G. (1972). *Steps to an ecology of mind*. New York: Ballentine Books.
- Bateson, G. (1980). *Mind and nature: A necessary unity*. New York: Bantam Books.
- Bruner, E. (1986a). Ethnography as narrative. In V. Turner & E. Bruner (Eds.), *The anthropology of experience* (pp.139-155). Chicago: University of Illinois Press.
- Bruner, E. (1986b). Experience and its expression. In V. Turner & E. Bruner (Eds.), *The anthropology of experience* (pp.3-20). Chicago: University of Illinois Press.
- Burr, V. (1995). *An introduction to social constructionism*. London: Routledge.
- Drewery, W., Winslade, J., & Monk, G. (2000). Resisting the dominating story: Toward a deeper understanding of narrative therapy. In R. A. Neimeyer & J. D. Raskin (Eds.), *Constructions of disorder* (pp. 243-264). Washington, DC: American Psychological Association.
- Fairclough, N. (1992). *Discourse and social change*. Cambridge, UK: Polity Press.
- Foucault, M. (1972). *The archeology of knowledge* (A. Sheridan-Smith, Trans.). New York: Harper & Row.
- Foucault, M. (1979). *Discipline and punish: The birth of the prison*. Middlesex, UK: Peregrine Books.
- Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings*. New York: Pantheon Books.
- Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: W.W. Norton.
- Freeman, J., Epston, D., & Lobovits, D. (1997). *Playful approaches to serious problems*. New York: W.W. Norton.
- Gergen, K. (1985). The social constructionist movement in modern psychology. *American Psychologist*, 40(3), 266-275.
- Gergen, K. (1994). *Realities and relationships: Soundings in social construction*. Cambridge, MA: Harvard University Press.
- Gergen, K. (1999). *An invitation to social construction*. Newbury Park, CA: Sage Publications.
- Gergen, K. (2001). *Social construction in context*. Newbury Park, CA: Sage Publications.
- Harker, T. (1997). Therapy with male sexual abuse survivors: Contesting oppressive life stories. In G. Monk, J. Winslade, K. Crockett, & D. Epston (Eds.), *Narrative therapy in practice: The archaeology of hope* (pp.193-214). San Francisco: Jossey-Bass.
- Hoffman, L. (1993). *Exchanging voices: A collaborative approach to family therapy*. London: Karnac Books.
- Hoffman, L. (2001). A communal perspective for relational therapies. *Journal of Feminist Family Therapy*, 11 (4), 5-17.
- Kogan, S. M., & Gale, J. E. (1997) Decentering therapy: Textual analysis of a narrative therapy session. *Family Process*, 36, 101-126.
- Lyddon, W. J. (1995). Cognitive therapy and theories of knowing: A social constructionist view. *Journal of Counseling and Development*, 73, 579-585.
- Lyle, R. R., & Gehart, D. R. (2000). The narrative of ethics and the ethics of narrative: The implications of Ricoeur's narrative model for family therapy. *Journal of Systemic Therapies*, 19(4), 73-89.
- McNamee, S., & Gergen, K. J. (1999). *Relational responsibility: Resources for sustainable dialogue*. Newbury Park, CA: Sage Publications.
- Minuchin, S. (1998). Where is the family in narrative family therapy? *Journal of Marital and Family Therapy*, 24, 397-404.
- Minuchin, S. (1999). Retelling, reimagining, and re-searching: A continuing conversation. *Journal of Marital and Family Therapy*, 25, 9-14.

- Monk, G., & Sinclair, S. L. (2001). *Narrative therapist as sociopolitical activist*. Unpublished manuscript, San Diego State University.
- Monk, G., Winslade, J., Crocket, K., & Epston, D. (1997). *Narrative therapy in practice: The archaeology of hope*. San Francisco: Jossey-Bass.
- Parry, A., & Doan, R. E. (1994). *Story revisions: Narrative therapy in the postmodern world*. New York: Guilford Press.
- Payne, M. (2000). *Narrative therapy: An introduction for counselors*. London: Sage Publications.
- Penn, P. (2001). Chronic illness: Trauma, language, and writing: Breaking the silence. *Family Process, 40*, 33-52.
- Penn, P., & Frankfurt, M. (1994). Creating a participant text: Writing multiple voices, narrative multiplicity. *Family Process, 33*, 217-231.
- Penn, P., & Sheinberg, M. (1991). Stories and conversations. *Journal of Strategic and Systemic Therapies, 10*(3/4), 30-37.
- Shotter, J. (1989). Social accountability and the construction of you. In J. Shotter & K. J. Gergen (Eds.), *Texts of identity* (pp.133-151). London: Sage Publications
- Smith, C. (1995). *One way of incorporating two different narrative therapy approaches: Collaborative language systems and deconstructive-externalizing*. Paper presented at Narrative Ideas and Therapeutic Practice: The Third Annual International Conference, Vancouver, B.C., Canada.
- Smith, C. (1997). Introduction: Comparing traditional therapies with narrative approaches. In C. Smith & D. Nylund (Eds.), *Narrative therapies with children and adolescents* (pp. 1-52). New York: Guilford Press.
- Tamasese, K., & Waldegrave, C. (1996). Cultural and gender accountability in the "just therapy" approach. In C. McLean & M. Carey (Eds.), *Men's way of being: New directions in theory and psychology* (pp. 51-62). Boulder, CO: Westview Press.
- Van Dijk, T. A. (1993) Principles of critical-discourse analysis. *Discourse and Society, 4*, 249-284.
- Wetherell, M., & Potter, J. (1992). *Mapping the language of racism: Discourse and the legitimation of exploitation*. New York: Harvester-Wheatsheaf.
- White, M. (1992). Deconstruction and therapy. In D. Epston & M. White (Eds.), *Experience, contradiction, narrative, and imagination*. (pp.109-151). Adelaide, Australia: Dulwich Centre Publications.
- White, M. (1997). *Narratives of therapists lives*. Adelaide: Dulwich Centre Publications.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W.W. Norton.