

Discursive therapy?

Tom Strong
University of Calgary

Andy Lock
Massey University

We contend that the talk of therapy, like everyday talk, is where and how people construct their understandings and ways of living. This is the fundamental insight of the social constructionist, or discursive, therapies. 'Meaning' is not some pre-given 'thing' that is communicated more or less successfully from one individual to another. Rather, 'meanings' are negotiated or constructed in the process of communication until each party is clear that they have a grasp of what they are 'talking about'. Similarly, 'meanings' are not universal, nor necessarily arranged in a given ethical hierarchy, with some absolutely superior to others: 'meanings' are local and accountable in their locality. Yet, meanings, and actions following from them, are central to the conversations of therapy. In our view, the social constructionist or discursive therapies point to enhanced possibilities for collaborative and relevant conversations with clients. In this article we summarize themes common to contemporary discursive approaches to therapy (examples: narrative, solution-focused, social and collaborative language systems therapies).

...within whose intralinguistic realities is
all this judging and correcting to be done?
—John Shotter, 1993, p. 141

For an endeavour that is largely based on conversation it might seem obvious to suggest that therapy is discursive. After all, therapists and clients use talk, or forms of discourse, as their primary means to accomplish psychotherapeutic aims. But, in the relatively recent tradition of therapy, talk or discourse has usually been seen as secondary to the actual business of therapy—a necessary conduit for exchanging information between therapist and client, but seldom more. Therapy primarily developed, as have most applied sciences (e.g., medicine and engineering), by mapping particular experiential domains in ways responsive to human intervention. The role that discourse plays in such mapping and intervening endeavours—whether by scientists or lay folk—has only recently been recognized as a focus for analysis and intervention. This recognition has Copernican implications, and not only for therapy. It serves to remind us that the phenomena of our experience cannot objectively announce their meanings and implications to us. Talk is not a neutral 'tool' used to get 'the real work' done: talk is where the real work of therapy happens (Friedman, 1993; Maranhão, 1986).

An increasing number of practitioners formulate therapy as a discursive practice—as have other social researchers such as critical social psychologists,

health psychologists, mediators, management consultants, etc., in their own areas of interest. Discursive approaches to therapy place discourse or talk central to the understandings and practices of therapy. This paradigmatic development has been occurring for a number of reasons; most importantly, because it is by using forms of discourse that we are able to understand each other.

In most cases, the bases for these new formulations (examples: narrative, solution-focused, social, and collaborative language systems therapies) are commonly shared, though often with different emphases. It can, however, be quite difficult to gain an understanding of those traditions that variously contribute to these formulations. This is hardly surprising. The ideas inspiring these therapies derive from often abstruse and arcane academic writing that no practitioner really wants to be a scholar of: life is too short for that.

There has recently been, however, a tendency to talk about the world as if it has become a 'post-modern' or a 'post-Enlightenment' one (Toulmin, 1990). Most of those talking this way claim that 'Truth' is socially constructed and relative to the time and place of its use. This starkly contrasts with the 'modern' approach of philosophers and scientists who sought (and continue to seek) universal truths about 'how things really are.' Regardless, arguments for a 'post-' point of view have found a growing currency within the human sciences and services. 'Psychiatric truths,' for example, can be compellingly analysed as suspect accounts of what is 'really going on'; or they may be characterised as 'regimes of power' (Foucault, 1984) rather than value-free practices that follow from 'what is clearly the case.' Does this mean that scientific medicine is all bad? That much of what it uses to inform its practice is just relative? That you would want to go to a post-modern dentist?

Questions like the preceding seem to call for knockdown answers (see Edwards, Ashmore & Potter, 1995) until one unpacks their presuppositions. For example, a therapist's inquiries or interventions can hardly be given the same technological capacity as a dentist's drill. Nor can one turn to the social sciences for the certainties found in the natural sciences. Thinking discursively is not a science- or technology-defying move; few postmoderns are ready to give up their laptops or cell phones. Also, characterizing well-intentioned psychiatric professionals as 'engaged in truth regimes' invites understandable antagonism. Rhetoric contrasting these 'sides' can sidetrack forward movement in either.

Discursive or 'postmodern' approaches to therapy are now commonplace, and 'modern' approaches are as vibrant as ever. Like many develop-

ments with premises different from those that preceded them, the discursive therapies found some of their appeal in their 'post' identity. At the same time, postmodern therapists trumpet their inclusivity, which assumedly would extend to others practicing different approaches to therapy. Here, we would like to focus on what we feel are some general features in the developing story of discursive approaches to therapy. What discursive thinking can bring to therapy, generally, is a greater awareness of how language features in what we understand and what our communications produce.

A Discursive Perspective

...once we abandon ordering arguments or concerns as giving us our true identities or our only genuine access to the world, we can begin nurturing our various cultural concerns and their various modes of inquiry.

—Spinosa, Flores & Dreyfus, 1997, p. 158

Naming, understanding and meaning-making are human undertakings realized differently across social contexts. Common sense, from this perspective, is not universal; it is recognized and practiced differently in such local contexts (Garfinkel, 1967). Where modernity promised a universally knowable world that could be understood in a correctly used language, other discursive streams or contexts of meaning—approximating Wittgenstein's (1953) 'forms of life'—have always flourished.

As 'forms of life' implies, this view of discourse sees people talking and interacting in distinct ways that shape their meanings and accomplishments. And even if we don't accept a world that can be objectively talked about, our 'common sense' can still create for us a similarly homogenized view of 'how things are': we can thus find ourselves living in our own blinkered monoculture in the face of cultural diversity. Discursive thinking reminds us that we have to be prepared to engage with other forms of common sense (Kögler, 1996), that charting a social course with ours alone is highly problematic. It is for this reason that discursive approaches to therapy require going off the 'auto-pilot' of our accustomed ways of talking and understanding, to participate in meanings and ways of talk unfamiliar to us.

A discourse perspective sees our ways of talking and interacting and our ways of thinking as integrated. Vygotsky (1978) suggested that our ways of thinking arise through how we learn to interact with each other. And it is conceptually difficult to see thought as unrelated to the social world to which we must respond. Most therapists, for example, are trained to be

cognizant of the ideas that inform how they talk and practice with clients. Philip Cushman (1995) extends his analyses beyond this: therapists and clients jointly participate in dominant socio-cultural discourses that shape their views on problems, solutions, and practice. Psychotherapy in the Victorian era therefore was based on different problems, solutions and therapeutic practices than today. Not surprisingly, our thoughts, like our conversations, can be seen as shaped or constrained by such dominant discourses.

Some discursive thinkers go further by suggesting that our thinking relates to imagined or anticipated conversations and interactions; that we learn to incorporate the responses of others into how we think about them (Bakhtin, 1984). Bringing these two discursive streams of thought together, our thinking can be regarded as shaped by cultural discourses, and the responses we make (or anticipate making) to more immediate communicative interactions (Billig, 1996). These shapers of our thinking/talking are more pervasive than most of us normally consider. This perspective on thinking is a far cry from the typical modern and western view that suggests that individuals have minds detachable from the goings-on of their relational, cultural and other circumstances.

Even more basic to discursive approaches to therapy is the idea that communication does more than just report or describe (Watzlawick, Beavin & Jackson, 1967). Users of discourses package understandings and how they can be related, and they do this in value-based ways that preclude other understandings or ways of relating them. How 'respect' is regarded and practiced in different family, social or cultural contexts serves as a case in point. Discourse, therefore, points to rule-like and value-based differences in how people systematically interact. Whether these differences are examined according to who speaks when, the non-verbals that complement or qualify messages, or in the words or subjects discussed—discourse can be seen as participatory and performative (Edwards & Potter, 1992). Said differently, discourse looks beyond any word, gesture or sentence, to systems of meaningful practice that inform people's interactions.

Complicating things further, people seldom participate in one discourse. The discourses of the workplace, while sharing some similarities, are usually different from those at home or in the community. Yet each can be seen as having requirements of its participants, requirements that participants themselves have played some role in holding each other to or shaping (Vološinov, 1973). To appreciate this, try managing family life or close personal relationships according to the discourses of work or the mar-

ketplace. Discursive approaches to therapy are therefore concerned with this participatory or performative aspect of communication (e.g., Newman & Holzman, 1997). It is in drawing from and making use of these discourses that we accomplish what we do with each other, and not all discourses serve us optimally in pursuing these accomplishments. Indeed, some discursive therapies invite clients to recognize and reflect on their accustomed discourses and to try on others that might better serve them.

Discursive therapy?

Philosophy is a battle against the bewitchment
of our intelligence by means of language.
—Wittgenstein, 1953, aphorism 109

Discursive approaches to therapy often focus more on *how* any therapeutic conversation occurs than on what such conversation is about, even though many discursive thinkers concede that conversation's whats and hows are highly correlated (e.g., Wittgenstein, 1953). Discursive therapists are therefore concerned with engaging clients, critically and practically, in the languages brought to and used in therapy. For them, this requires participative dialogue where clients' preferences, understandings and resources are central to determining how therapy will proceed. This sharing of therapeutic decision-making can be seen as an ongoing negotiation. So for that matter can all endeavours in arriving at therapy's understandings. This fits what John Shotter (1993) has referred to as "joint action." Simply telling someone that their experience is 'X' will not mean they understand or accept 'X' as an account of their experience. Furthermore, given culturally-conferred and other power differentials between client and therapist, extraordinary efforts are often taken so as to be inclusive of the experiences and preferences of clients (Parker, 1999).

For discursive therapists, the therapeutic conversation is where and how change happens (deShazer, 1994). When clients' presenting problems and solutions can be seen as discursively related to how they are regarded and talked about, therapy can be helpful insofar as it helps us put words to the inarticulable. However, it also can be helpful should it: dis-solve a concern (Anderson, 1997); generatively challenge our assumptions and introduce new perspectives, prompt aha's where we find our own solutions; or inspire us to look beyond our normal cognitive horizons. Thus, discursive therapy sees change occurring in the back and forth of communicative interaction.

A question, from this perspective, can serve as a potent intervention (Tomm, 1988). Other forms of therapy often see such talk as neutral ways of gathering data to formulate problems and justify their theory-related interventions.

Discursive thinkers and practitioners are curious about what people do with their talk, how they use it to influence each other (Austin, 1962). To the extent that therapy helps clients make desired changes, discursive therapists use particular conversational strategies, such as questions, to keep therapy relevant and 'on track' from the client's perspective. What clients do with what therapists say, and what therapists then say in response to what clients have said in response to them (and so on), are key features of recognizing that the talk of therapy is consequential in ways that the therapist can respond to, to keep things 'on track' (Walter & Peller, 1992). In discursive therapy, the therapist is therefore attentive to his/her use of language (and the client's) for what that use accomplishes—with respect to the client's presenting concerns and with respect to the therapeutic relationship. This attentiveness and responsiveness to what is accomplished—at its most microscopic—plays out at each conversational turn and is at the heart of what Donald Schön (1983) referred to as "reflective practice."

Discursive therapists often promote curiosity about what our participation in any discourse obscures or has us take for granted (White, 1993). What passes for real or good in our lives is seldom seen as a discursive matter. Asking others how they came to understand what has seemed undeniably real or good to them—in the particular way that they have—can seem revolutionary. This, among other ways that discursive therapists might intervene, raises an ethical dimension seldom considered in other approaches to therapy. If meanings aren't out there to be named and acted upon correctly—if there are other ways for experience to be named and related to—what are we then to make of the meaning-altering influences of the discursive therapist?

Here, it helps to bear in mind notions from hermeneutics (e.g., Taylor, 1989) or critical discourse analysis (e.g., Wodak & Meyer, 2001) that, for a meaning to achieve the status of real or good, other contenders for that status were subordinated. 'Authority' regarding meaning has historically fallen to religious, political and scientific figures who took turns as determiners of 'the way things are or should be.' In the postmodern era many meanings are contested or seen to triumph. Therapy itself is a place where the implications of dominant or subordinated meanings can be explored, including those put forward by therapists. Abandoned is the notion that therapists possess better understandings of the circumstances and vicissitudes of clients' lives

and thereby should proffer such 'correct' meanings or actions to clients. In discursive approaches to therapy one aim is to collaboratively and critically engage clients in processes that yield meanings they consider effective for their lives (Andersen, 1991). Discursive therapists, therefore, are sensitive to their use of talk in these processes, careful to not place clients in subordinate roles that further alienate them from scrutinizing and making meanings relevant to their lives, in or beyond therapy.

Discursive therapists view humans as users of language, most often from discourses that dominate their ways of talking and relating. To that end, humans are sometimes poets or authors (when seeking optimal ways to express our experiences and desires), sometimes salespeople or politicians (when trying to negotiate our coexistence with others), and sometimes cartographers or architects (when trying to map or construct language to suit our purposes in physical reality). But it would be plain wrong to suggest that we can use whatever words we want. While discourses package our ways of talking and relating, those that dominate furnish certain possibilities while constraining others (Martin & Sugarman, 1999). Consider this partially as a resource issue. For example, to what extent does biomedical discourse furnish words and ways of talking that can relieve suffering? It does if one speaks of diagnosable symptoms for which medical intervention can make a difference. But such a way of talking seldom turns poetic, where sufferer and caregiver articulate quality of life understandings amenable to other, non-medical forms of intervention. This need not digress into an either/or issue about which discourse should dominate; both offer possibilities and limitations. What matters is how people resourcefully interact within or across discourses. While not determined by their participation in a discourse, the words and ways of talking any discourse affords typically sets parameters for how people can resourcefully improvise or work out their interactions. This includes any discourse, understanding or practice developed within therapy that departs from those commonly used in the contexts where clients may use them. Therapeutically, one challenge rests in how and from where words and discourses can be resourcefully and improvisationally drawn, where certain limiting meanings and ways of talk had previously dominated.

Summarizing thoughts

How might a discursive perspective on therapy be conceived in terms of orienting ideas and practices? Here are a few summarizing thoughts on

what we have been saying:

1. All understandings and practices brought to, or developed in, therapy are 'locatable' to particular discourses, including the therapist's;
2. discursive awareness helps us recognize that any discourse affords some resourceful possibilities, while constraining others;
3. talk itself is consequential for relationships and what is subsequently talked about. My talk is shaped by others' prior and anticipated talk, and by our talking 'within' a dominant discourse;
4. misunderstandings, or failures to coordinate therapeutic intentions, suggest that a discourse is needed or must be negotiated;
5. the discourses used to solve problems often need to be different from those initially used to understand and present them;
6. all understandings and solutions developed in therapy are tested in interactions beyond therapy. Sometimes this is where things get stuck;
7. therapeutic culture is also discursively constructed in dominant ways. A therapist's dominant model or aggregate of therapeutic constructs and practices was itself constructed in a discursive context in which some resources are foregrounded more than others.

References

- Andersen, T. (1991). *The reflecting team: Dialogues and dialogues about the dialogues*. New York: Norton.
- Anderson, H. (1997). *Conversation, language and possibilities*. New York: Basic Books.
- Austin, J.L. (1962). *How to do things with words*. (J.O. Urmson, Ed.) Cambridge, MA: Harvard University Press.
- Bakhtin, M. (1984). *Problems of Dostoevsky's poetics*. (C. Emerson. Ed. & Trans.). Minneapolis: University of Minnesota Press.
- Billig, M. (1996). *Arguing and thinking*. (2nd ed.) New York: Cambridge University Press.
- Cushman, P. (1995). *Constructing the self, constructing America: A cultural history of*

psychotherapy. Cambridge, MA: Perseus.

DeShazer, S. (1994). *Words were originally magic*. New York: Norton.

Edwards, D. & Potter, J. (1992). *Discursive psychology*. London: Sage.

Edwards, D., Ashmore, M., & Potter, J. (1995). Death and furniture: The rhetoric and politics and theology of bottom line arguments against relativism. *History of the Human Sciences*, 8, 25-49.

Foucault, M. (1984). *The Foucault reader*. (P. Rabinow, Ed.) New York: Pantheon.

Friedman, S. (Ed.) (1993). *The new language of change*. New York: Guilford.

Garfinkel, H. (1967). *Studies in ethnomethodology*. New York: Prentice Hall.

Köglér, H-H. (1996). *The power of dialogue: Critical hermeneutics after Gadamer and Foucault*. (Trans. P. Hendrickson) Cambridge, MA: MIT Press.

Maranhão, T. (1986). *Therapeutic discourse and Socratic dialogue*. Madison, WI: University of Wisconsin Press.

Martin, J., & Sugarman, J. (1999). *The psychology of human possibility and constraint*. Albany, NY: SUNY Press.

Newman, F., & Holzman, L. (1997). *The end of knowing*. New York: Routledge.

Parker, I. (Ed.) (1999). *Deconstructing psychotherapy*. New York: Routledge.

Schön, D. (1983). *The reflective practitioner: How professionals think in action*. New York Basic Books.

Shotter, J. (1993). *Conversational realities: Constructing life through language*. London: Sage.

Spinoza, C., Flores, F., & Dreyfus, H.L. (1997). *Disclosing new worlds: Entrepreneurship, democratic action and the cultivation of solidarity*. Cambridge, MA: MIT Press.

Taylor, C. (1989). *Sources of the self: The making of modern identity*. Cambridge, MA: Harvard University Press.

Tomm, K. (1988). Interventive interviewing. Part III: Intending to ask lineal, circular, strategic or reflexive questions. *Family Process*, 27, 1-15.

Toulmin, S. (1990). *Cosmopolis: The hidden agenda of modernity*. Chicago: University of Chicago Press.

Vološinov, V.N. (1973). *Marxism and the philosophy of language*. (Trans. L. Matejka & I.R. Titunik). New York: Seminar Press.

Vygotsky, L. (1978). *Mind in society: The development of higher psychological processes*. (Michael Cole, Ed.) Cambridge, MA: Harvard University Press.

Walter, J., & Peller, J. (1992). *Becoming solution-focused in brief therapy*. New York: Brunner-Mazel.

Watzlawick, P., Beavin, J., & Jackson, D.D. (1967). *Pragmatics of human communication: A study of interactional patterns, pathologies and paradoxes*. New York: Norton.

White, M. (1993). Deconstruction and therapy. In S. Gilligan & R. Price (Eds.) *Therapeutic conversations*. (pp. 22-61). New York: Norton.

Wittgenstein, L. (1953). *Philosophical investigations*. (Trans. G.E. Anscombe). Oxford: Blackwell.

Wodak, R., & Meyer, M. (Eds.). (2001). *Methods of critical discourse analysis*. London: Sage.