

Postmodern Psychotherapeutic Ethics: Relational Responsibility in Practice¹

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It is clear that ethics cannot be formulated (Wittgenstein).

The field of psychotherapy (as most professional fields) has been fraught with a concern for ethical action where ‘ethical action’ generally infers “doing the right thing.” Yet, when we operate within a postmodern sensibility – a world that embraces uncertainty as opposed to certainty, continual change as opposed to stability, and local/historical/cultural contingencies rather than universal laws – answering the question of what counts as ethical practice requires an entirely different focus of attention. Traditionally, the belief has been that we can judge individuals and their actions, thereby making assessments of the appropriateness or ethical quality of those actions. The criteria for ethical action within a traditional orientation are assumed to be empirically supported and applicable across contexts. In postmodernism, however, we shift our focus in two important ways: (1) from believing that there could be one, uniform set of criteria for assessing the ethics of any particular action and (2) from centering individuals and their actions to centering processes of relating. These shifts demand that we approach the question of ethical action in a radically different manner.

Traditions of Psychotherapy

Like any other cultural institution, psychotherapy is imbued with a wide range of expectations. One insidious expectation is the idea of a deficiency or weakness within the person. Put bluntly, people go to therapy because they “have” some internal flaw. That the flaw is psychosis or marital problems

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matters little. What is of paramount importance is correcting the deficiencies within the person. Although the therapeutic process is often justified on the grounds that it empowers those who are dependent due to their deficiencies, there is an important sense in which the reverse is true. Diagnosis, a central aspect of traditional psychotherapy, is frequently a main vehicle for disempowerment. The logic of disempowerment becomes most clear in the works of Michel Foucault (1973). In Foucault's terms, when we offer ourselves for examinations of various sorts, we are giving ourselves over to disciplinary regimes, to be labeled and explained in their terms. Each discipline, each unique model of psychotherapy, provides its own special vocabulary for categorizing and explaining the problems clients bring to the therapeutic context. And when we carry these terminologies into our daily lives, speaking to others of our depression or our anxiety, we engage in power relations - essentially extending the control of the disciplinary regimes. As our disciplines of study begin to influence public policy and practice, we become further ordered in their terms. As diagnostic terminology is increasingly sanctioned by managed care systems, it becomes increasingly difficult to escape. And as pharmaceutical companies increasingly profit from curing those labeled, they contribute to the disempowerment of the individual.

Let us consider for just a moment the specific ramifications of this individualist² focus in psychotherapy as it relates to the issues of ethics and responsibility. While it is the case that there are many modes of psychotherapy where emphasis is placed on moving beyond personal or psychological distress, the profession requires first and foremost that a diagnosis be identified before moving toward problem resolution or treatment. In fact, because psychotherapy is tightly linked to the medical profession, the overwhelming belief is that psychotherapy, in order to proceed, *demand*s diagnosis. How could a therapist know how to treat a client if that therapist was operating without a clear idea of what the client's problem was in the first place? To treat a problem requires diagnosis. Two issues are relevant here: (1) the issue of diagnosis as identifying a deficiency that resides within the person and (2) the issue of diagnosis as a necessary conversation (particularly in psychotherapy) that revolves around identification of problems, the causes of the problems, and the resolution of problems. These issues are not necessarily separable and have significant implications for what we deem ethical and responsible

2. Elsewhere (McNamee, 1996) I have written about the individualist philosophical stance that is referred to as the taken-for-granted tradition and thus I refer to the tradition and individualism (as well as modernism) interchangeably.

interaction. Yet let me expand just a bit on each of the above issues to set the context for an alternative.

Diagnosis of individuals. Central here is the observation that diagnosis in psychotherapy means diagnosis of an individual. If *the self* is the focus of therapy and that self is located within the person, as individualism tells us (see Sampson, 2008), then all that is problematic must emanate from the internal mind, psyche, brain function, etc. of that self. Thus the diagnosis must be of the person (the individual and his or her *features*). There are certainly situations where such diagnosis can be useful. I think of the varying responses different people might have to the diagnosis of chronic depression. For some, learning from the “expert” (psychotherapist) that they are suffering from chronic depression can be helpful. The diagnosis affords a feeling of possibility; now that the problem has been identified, a treatment program can begin. There is hope in sight.³ Yet we must not forget all those others for whom the diagnosis of chronic depression (or any diagnosis for that matter) initiates a tailspin into further malaise. Labeled with their diagnosis, any hope to be “normal” is lost by virtue of being identified as flawed, inferior, unhealthy.

Diagnosis requires problem talk. Psychotherapy, diagnosis and problems are terms that naturally go together. We seek psychotherapy when we feel uneasy, unsettled, or disturbed or when those around us find us uneasy, unsettling, or disturbing! When things are not going well in our lives, psychotherapy is one of the central places we turn for help. Given the assumption that psychotherapy deals with *problems*, it is difficult to imagine the utility of a psychotherapeutic conversation where the central topic of discussion is not, in fact, problem oriented.

Ethics as Social Construction: Relationally Engaged Practice

An alternative orientation to the traditions of diagnosis and problem talk can be found in social construction.⁴ Viewing therapy as social construction

3. In using this illustration I am not suggesting a “situational ethics.” Many who see therapy as a process of social construction have invited their clients into a reflexive conversation concerning the dominating discourse of diagnosis, thereby opening the client to reflect on the purpose and practice of diagnosis itself. This is often accomplished by outlining the professional requirements for diagnosis and acknowledging that, given these requirements, the best way to move in a relationally responsible therapeutic context is to collaborate with the client on the selection of a diagnosis.

4. My 1992 volume, co-edited with Kenneth Gergen, is purposively entitled, *Therapy as Social Construction* rather than *Social Constructionist Therapy* to indicate our focus on a stance or

opens the therapeutic conversation to a broader range of issues. Specifically, it is to entertain the question: What can we accomplish (i.e., create) in our conversations together? *This question is a question of ethics.* There are multiple ways in which personal and relational transformation can occur. Diagnosis and problem talk might be generative, as might conversations focused on strengths, values, and future possibilities. When we view therapy as social construction, we are not particularly interested in pre-determining what sort of interactions will produce transformation. We are more concerned with adopting what I refer to as a *relationally engaged* stance with clients. Within such a stance, the ethic of psychotherapy is one of being relationally responsible (McNamee and Gergen, 1999). A relational, postmodern ethic is one of knowing *how* to be attentive to the *process* of opening viable possibilities and potentials for those with whom we work. This requires focus on what therapist and client do together in the therapeutic conversation because we can never “know” outside of any given context or, more specifically, outside of the interactive moment.

I am not suggesting that diagnosis is bad or wrong. Rather, my point is that when we explore therapy as social construction, our attention is focused on how therapist and client, together, might expand the range of resources for action. This *might* require the therapist and client to construct a relationship wherein the therapist becomes the expert or authority, and, in particular, the expert who is capable of providing a diagnosis and treatment plan. Yet, it also might require the therapist and client to construct a discursive domain where the interaction departs from the cultural expectations of psychotherapeutic conversations (i.e., therapist as diagnostic expert). Here, the therapist and client might work together to create a conversational space where the therapist’s role as expert is not central. When we are relationally engaged, we enter into conversation with no clear a priori notion of who⁵ we should be (expert, authority, or equal conversational partner) nor of who the client *should* be (needy, incapable of helping him/herself, friend).

The constructionist asks, *What do we do, as therapists, once we propose that meaning emerges in the on-going flow of persons in situated activity? How do we know when clinical practice is responsible and ethical?* Answering these questions

orientation with which we approach therapeutic process as opposed to a focus on any specific type of therapy (e.g., a model). As constructionists, we are interested in exploring therapy (and any other context or phenomena) first and foremost as a conversation wherein realities are crafted.

5. Of course, we enter with our professional identities and obligations but our relational sensitivity positions us to not know ahead of time how that professional identity or those professional obligations will unfold with this particular client in this particular context.

requires attending to what people do together, that is, what I refer to as *language practices*⁶. When our concern is on what people are doing together, our curiosity is on knowing how certain patterns unfold – by being attentive and responsive – rather than the traditional, expert position of knowing that certain actions (contents) are right or wrong, good or bad, ethical or unethical. Here we clearly see the distinction that within a traditional worldview, emphasis is on the expert’s knowledge – what the therapist knows about therapeutic process, psychic and relational aspects of being, and so forth. A good clinician is one who knows *that* certain behaviors or descriptions indicate a particular diagnosis. Within a postmodern/constructionist worldview, however, the professional does not position him or herself as a “knowing professional” but as one who is curious to know *how* the client’s life-world unfolds. The distinction, again, is an attention to process as opposed to content or product.

From a Professional Ethic to an Ethic of Discursive Potential

A constructionist stance embraces diversity. Diversity is the starting place for all engagement. We assume diversity and change rather than search for commonality and stability as traditional psychotherapy models do. The constructionist acknowledges the multiple and conflicting moralities we each confront daily.⁷ It is barely possible to move through a single day without confronting moral opposition, let alone significant differences in moral stance. We all operate within moral orders each time we utter to ourselves or others the “oughtness” or “shouldness” of a given action or set of actions; words we often hear in defense of working in a particular way with a particular client. To that end, we need not leave the issue of morality in the hands of ethicists or philosophers. Rather, the exploration of diverse moralities should be a common focus for us all since every morality is constructed in our day-to-day interactions with one another – and therapist and client are very much part of this day-to-day flow.

With our stories, and in our interactions with others, we craft our worlds. The moral orders within which we live are emergent products of the flux and flow of daily engagement that is always situated historically and culturally

6. I use the term *language practices* to avoid the naïve critique frequently leveled on social construction: if all is reduced to language, entire aspects of social interaction and human meaning making are ignored such as non-verbal action, relations with the environment, and the ineffable. In using the term, *language practices*, I am implicating all activity including relations with one’s environment and interactions that are “beyond words.”

7. See footnote 2.

within what we come to know as dominant discourses. The dominant discourses are those ways of understanding that are taken-for-granted as “true” or “right;” they largely go unquestioned. And yet, because what one community takes for granted as true is likely to differ from what another community takes to be true, the possibility that one or another might respond differently to our actions is always ready to hand. To this end, the moral character of everyday life rests on the contingent quality of our conversational engagements, couched as they are within dominating discourses of right and wrong, and thus those engagements – those interactive processes – become our necessary focus of attention. Ironically, in traditional psychotherapy, our situated engagements perpetuate and re-construct the very dominating discourses (such as the discourse that says diagnosis is ethical) by which we feel ordered.

This is no minor point. As therapists we are compelled, within a constructionist orientation, to recognize the ways in which our own “ethical” actions are both determined by and determinant of the taken-for-granted understanding of what is professionally ethical. My attempt here is not to argue that certain practices or views are right or wrong but to open for collective consideration whose interests are at stake when we act unquestionably in accordance with universalized professional ethics (i.e., the dominant discourse). If we believe that a client presents a danger to his or her family, does removing the client from the family context help alleviate or exacerbate that danger? Is medicating a client who is diagnosed as depressed helping the client or helping the client’s employer? Does a diagnosis of ADHD for a young child assist over-worked parents and teachers or the child? These are challenging questions to confront and it is not the case that a constructionist ethic of relational responsibility equips us with the “correct” answer. Rather, the point is that the ethic of relational responsibility equips us with the reflexive vocabulary to ask questions of these taken-for-granted truths (i.e., dominant discourses).

The ethic of psychotherapy, within a constructionist stance, is an exploration of *what people (therapist and client) do together and what their doing makes*. These activities are always locally and historically situated. To that end, there is a shift in focus from the “rightness” or “health” of a client’s actions – temporarily – to a consideration of the *conditions* and *resources* that grant coherence to those actions such that alternative understandings might emerge. Thus, the taken-for-granted discourse of, in this case, pathology and deficit is challenged. We make meaning in our coordinated activities with others. Thus, it is our coordinations that command our attention, as opposed to our application of de-contextualized models, theories, or techniques.

Recall that, for the constructionist, language practices (all embodied activities in which people engage) are the focus of our concern. It is in our activities with others that we create the worlds in which we live. Thus, it should come as no surprise that in therapy, we are focused on how particular discursive moves constrain or potentiate different forms of action and, consequently, different realities. This is a liberating stance because when we become curious, as opposed to judgmental, about how people engage with each other, we open ourselves to the consideration of alternatives. This particular feature is often associated with the constructionist focus on *uncertainty*. Attention to language practices positions us in a reflexive relationship to our own actions as well as to the actions of others. We are poised and prepared to ask, “What other ways might I invite this client into creating a story of transformation?” “How is she inviting me into legitimating/transforming/challenging her story?” “What other voices might I use now?” “What other voices might he use?” and so on.

The therapeutic ethic of relational responsibility is not a better stance to take in the psychotherapeutic context. It is not a technique. Rather, it is an orientation to therapeutic process that privileges what is happening in the conversation, in the interactive moment. The focus is on dialogic processes, not on people, situations, or problems in isolation. This is a significant difference because it positions *any* method of therapy as a potential resource for use. Behavioral, cognitive, psychoanalytic, narrative, solution focused, and so forth become *potentially* viable and generative ways of relationally engaging with clients. This is because all models, theories, and methods are seen as *discursive options* as opposed to scientifically tested ways of discovering or depicting aspects of the person or world (i.e., Reality).

Theories and Techniques as Discursive Options

Any particular discourse (or in this case, any particular theory or model) becomes a potential resource for transformation rather than a tool that will *bring about* (read: cause) transformation. The question of what is therapeutic (and thus ethical) remains open and indeterminate, just like conversation. Using the metaphor of therapy as a *conversational process*, suggests that, like ordinary conversation, we can never be certain where it will go. I can never fully predict another’s next move and consequently, the potential for moving in new directions, generating new conclusions and possibilities (and constraints) is ever-present. What we can do, however, is remain attentive to the conversational resources we select and which ones might serve as useful alternatives. It is important at this point to emphasize that (1) we make no attempt in constructionist practice to act in a particular manner – beyond

remaining responsive to the interactive moment, (2) we become relationally engaged by focusing attention on the interactional processes of all those involved (rather than on individuals, objects, problems, or specific strategies), and (3) we can not “know” what forms of relational engagement (what specific actions) will contribute to therapeutic change in advance.

This last point, in particular, can be very unsettling for many. But remember, therapy is like conversation. We can never anticipate precisely the outcome. Is this a problem? I don't think so. If we remain attentive to the process of relating itself, we will be attentive simultaneously to the additional voices we all carry (friends, colleagues, family, culture, and so forth). In so doing, we are more likely, I believe, to engage in inquiry that encourages multiple stories, multiple possibilities, and thus, the potential for therapeutic transformation.

Implications for a Relational Ethic of Clinical Practice

Ethical practice in the context of diverse and competing moral orders requires the ability to bring disparate ideas and practices into the conversation in ways that are *curious rather than judgmental*, thereby opening the possibility for coordination among multiple and competing moral orders. Ethical practice also invites participants to depart from their well-rehearsed descriptions of their problems and explore, instead, the multiplicity of possible voices they already hold but neglect to draw upon given the well-coordinated rituals they have crafted with others.

Selecting a theory or technique as a *practical option* for action (as opposed to a truthful option) enhances our ability to be relationally engaged with clients. We become sensitive to their stories, as well as our own, in ways that allow us to be responsive and therefore, relationally responsible. There are many ways in which we might pragmatically achieve such responsivity. I would like to identify five relational stances that could usefully focus our attention in an ethical manner as opposed to a more traditional focus on proper methods, techniques, or application of abstract theoretical concepts. I like to refer to these stances as *resources for action*. They are resources or forms of practice that guide our therapeutic work. Surely, many more can be added to the list. Consider how each might be useful in approaching *therapeutic process as relationally responsible activity and thus, constructing the potential for a relational understanding of clinical ethics*.

1. Avoid speaking from abstract positions. When we confront difference or what we might see as pathology, we most often resort to imposing our expert advice. This advice, however, is usually abstract. The warring principles of “right” and “wrong” beg the question: *whose standards are we using?* And since we understand that values, beliefs and realities are built from coordination within relationships, we can now anticipate some very different – and often incommensurate – values and beliefs will be housed within any therapeutic conversation. Inviting a person to tell a story about who in her life influenced her to honor and value certain beliefs and practices does not make the problem go away, but it does significantly transform the nature of the therapeutic conversation and, by extension, the nature of the relationship. By avoiding the discourse of abstraction (right/wrong, good/bad, healthy/unhealthy), a therapist can enter into a stance of *generative curiosity* where new forms of local, situated understanding emerge. The unique features of a client’s story are privileged thereby opening space for a different story, a different rationale, a different history. The therapist is much better equipped to continue the therapeutic conversation with this form of understanding.

2. Self reflexive and relationally reflexive inquiry.⁸ Here the attempt is to entertain doubt about our own certainties. We can invoke our inner voice of skepticism about our own strongly held beliefs. *Can I be so certain that there is absolutely no other way to look at this situation?* We can also invoke the doubtful voice of a friend, colleague, or mentor. *How would my mother, my colleague, my friend think about this?* This self reflexive inquiry opens us to the possibility of alternative constructions thereby transforming the nature of the interaction. Similarly, to pause and inquire about how the interaction with the client is going recognizes that the emergent meaning in a particular interactive moment is a byproduct of “us,” not of “you” or “me.” This is what John Burnham (2005) refers to as relational reflexivity. Thus to inquire, *Is this the kind of conversation you were hoping we would have? Is there another way we could or should be doing this? Are there questions I should be asking you but I’m not?* acknowledges that we only have “power with” and not “power over.”

3. Focus on the coordination of multiplicities. When we confront the challenges of difference, our tendency is to find any means to move toward consensus. Rather than approach conflicting moralities as opportunities to develop consensus or common agreement, our clinical impetus within a

8. I am indebted to John Burnham (2005) for introducing me to the idea of relational reflexivity.

relational ethic is to coordinate multiple discourses. The clinician is challenged to become curious about all forms of practice and to explore the values and beliefs that give rise to them without searching for universal agreement. Can we create dialogic opportunities that invite *generous listening, curious inquiry, and a willingness for co-presence*?

4. Use of our familiar forms of action in unfamiliar contexts. Often when we are stuck in therapeutic conversations we sense a loss of resources for achieving an effective outcome. Perhaps we have strong differences with our client's political views, life style choices, images of what it means to be a successful person. In those moments, do we turn to our well-studied techniques? Don't our clients expect, in fact, that therapists can teach successful strategies for change? I would like to suggest that learning *new* strategies for coordinating competing understandings of the world and self might not be necessary. Perhaps, therapists should not be in the business of teaching "new" skills to clients. Gregory Bateson talks about "the difference that makes a difference" (1972, p. 272) and Tom Andersen sees this difference as introducing "something unusual but not too un-usual" (Andersen, 1991, p. 33). Here, I am suggesting a variation on this theme.

We all carry with us many voices, many differing opinions, views and attitudes - even on the same subject. These voices represent the accumulation of our relationships (actual, imagined, and virtual). In effect, we carry the residues of many others with us; we contain multitudes (McNamee and Gergen, 1999). Yet, most of our actions, along with the positions we adopt in conversations, are one-dimensional. They represent only a small segment of all that we might do and say. The challenge is to draw on these other voices, these conversational resources that are familiar in one set of relationships and situations but not in another. In so doing, we achieve something unusual.

Using familiar resources in contexts where we do not generally use them invites us into new forms of engagement with others. If we think of all our activities as invitations into different relational constructions, then we can focus on how utilizing particular resources invites certain responses in specific relationships and how it invites different responses and constructions in others. All represent various attempts to achieve coordinated respect for the specificity of a given relationship and situation. If we can encourage ourselves (and others) to draw broadly on the conversational resources that are already familiar, perhaps we can act in ways that are *just different enough* to invite others into something beyond the same old unwanted pattern. To the extent that we can invite the use of the familiar in unfamiliar contexts, we

are coordinating disparate discourses. What we are avoiding is co-opting one discourse as right and another as wrong. The novelty of enacting the old in a new context becomes, I believe, fertile soil within which to craft a relational ethic of psychotherapy.

5. Focus on the future. If you examine problem-solving talk – the dominant discourse of psychotherapy – you will note that a good portion of what we think we “should” be doing, as we attempt to solve problems and negotiate competing moralities, focuses on the past. We explore the history and evolution of a problem. When did the problem begin? How long has it been a difficulty? How have participants come to understand (make sense of) the problem? What do they think is the cause of competing beliefs about this problem? What do others say about it? What have those involved done to try to solve this problem? The questions we ask direct our conversation to the past, as do the expectations of all participants (i.e., if we don’t talk about what caused the problem, we’ll never resolve it).

With such an emphasis on these past-oriented questions, there is little room for imagining the future. The potential to sediment the past, to reify the story, and thereby make it static and immutable is tremendous. Probably more important is the logic inherent in the focus on the past. By focusing on what has already transpired, we unwittingly give credibility to causal models that are the hallmark of modernist science. We privilege the logic that claims that what went before causes what follows.

I do not necessarily want to argue for a disconnection between past, present and future. I simply want to raise the issue of narration. The past is always a story. And we all know that there are many ways to tell a story. Not only do we harbor many voices, each with a different set of possible narrations, but others involved in the same “history” will very likely narrate it differently. Thus, the causality of past to present (and implied future) will take different turns, highlight different features, and pathologize or celebrate varied aspects depending on which story is privileged.

One reason that future-oriented discourse can enhance the coordination of competing world views is because we all understand that we do not yet *know* the future. We have not embodied it yet. And thus, to the extent that we engage *with others* (our clients) in conversation about the future, we underscore the relational construction of our worlds. We fabricate together the reality into which we might collaboratively enter.

This is not to suggest that talk of the past is wrong or emblematic of simplistic views of psychotherapy. I am proposing a collaborative, situated

creation of possibilities and *one way* to achieve this is with future-oriented discourse. In our talk of imagined futures, we invite coordination of many convergent and divergent understandings of the past and the present. Again, this form of relational engagement moves toward coordinated respect for multiplicity and difference.

Meeting the Ethical Demands of Contemporary Psychotherapy

In an era where “ethical” is often equated with “legal,” we must ask what a relationally responsible ethic of psychotherapy offers. Do the suggestions above allow therapists to “do the right thing?” Is “the right thing” equivalent to “the legal thing?” When our focus is placed only on the de-contextualized actions of de-contextualized individuals, the opportunity to act ethically is diminished – although the opportunity to act legally might be enhanced. We are confronted with the question of where the therapist places his or her priority. Is primary interest in helping clients or in acting in ways that do not unsettle the dominant (and often oppressive) discourses that contribute to our clients’ difficulties? If we are confronted with abuse or self-harming behaviors, can we be completely certain that we are acting ethically when we separate family members, institutionalize, or refer clients to special remedial programs? I am reminded of a story told by my colleague Ralph Kelly (personal communication). As a consultant, Ralph was invited to help a Women’s Shelter increase their potential for attracting abused women and their children to the shelter’s programs. The shelter staff was dealing with a long-standing problem wherein women would come to the shelter but find excuses to leave after having filled out the appropriate paperwork and having an initial interview with a shelter counselor. Ralph asked to see the questionnaire the women were required to complete. What he noticed was that all the questions asked on the intake form were questions that made the women feel like failures. They were asked how often they were abused, when the abuse was likely to happen, how long it had been going on, and so forth. Ralph’s observation was that by the time these women had completed the questionnaire, they were humiliated by what appeared to be their “choice” of relational partner. The questionnaire invited them (albeit unknowingly) to feel as if they “deserved” their abuse. They were too weak or too flawed to stop the abuse. Ralph’s simple suggestion was to change the intake form, designing questions that allowed these women to talk about the strength they had mustered to come to the shelter, the moments in their abusive relationships when they had successfully escaped abuse, and so forth.

These are the sorts of critical engagements that invite a relational ethic – one that is responsive to the other and, in so being, inviting of the generation of new resources for action. In traditional psychotherapy, the therapist’s job is to offer new forms of action to clients. In postmodern, relational psychotherapy, the therapist’s job is to create the conditions where both client and therapist can “surprise” themselves by the resources for action that might already be available. As mentioned above, a relational ethic has more to do with using the familiar in unfamiliar contexts than with expecting another to adopt an entirely new way of being.

The Provocative Issue on the Table for Psychotherapy

The challenge we face in psychotherapy is the challenge to keep the conversation going. In keeping the conversation going, we connect with diverse others in ways that are, as Rorty says, “more humane, enlightening, and respectful (Rorty, 1979, p. 394). I have tried to articulate that therapy as social construction cannot be coherently equated with an image of therapists and clients creating meaning *by some universal, objective standard*. Social construction hinges on the very important notion of **relational engagement**. We are all accountable not only to those with whom we engage in the therapeutic context, but we are also **relationally responsible** to a myriad of others within our professional, personal, cultural, and global communities.⁹

In sum, let me review what I see as the specific issues we must address to ensure responsible and ethical clinical practice. First, social construction, with its relational focus, presents a challenge to traditional notions of expert knowledge and professional neutrality. It is not the case that constructionists do not recognize expertise or authority. What constructionists call into question is the *unquestioned presumption* that the therapist *should* be the authority (and that it is only in the therapist’s position as authority or expert that psychotherapeutic success can be accomplished). I suggest that the task at hand is one of coordination among therapist, client, and the broader community within which they operate. That coordination might include problem talk, diagnosis, and an authoritative stance taken by the therapist.

9. Of course, this raises a significant issue that deserves much more discussion. How can any person or set of relationships be simultaneously responsible to competing and divergent communities? If a therapist is relationally responsible to his or her client, does this mean he or she is also relationally responsible to a professional oversight board? What happens when such relational responsibilities are incommensurate? In the age of managed care, this issue is clearly negotiated on the side of the insurance companies often at the expense (psychological, physical, relational, and financial) of the client.

It is also likely that it might require the therapist to adopt the stance of an equal conversational partner who does not know with certainty how to understand or make sense of the client's problem. Furthermore, it might involve conversation about possibilities, potentials, ideals, and so forth. The point is, from a constructionist stance, we cannot know ahead of time what will be the most generative therapeutic relationship for any given client.

Second, constructionism raises the question of focus. Traditional therapy focuses on the past to understand the present. Therapy informed by a constructionist sensibility places focus on the process of relating or, put otherwise, the *interactive moment* – the past, present, and future as they are narrated in the present. To that end, rather than attempt to provide clients with new resources for action, therapy attempts to help clients utilize the conversational resources they already have, in new and unusual conversational arenas. Additionally, the therapeutic conversation might focus on the future, as well as on the discourse of the ideal.

Finally, there is a difference between ignoring the past (as it is narrated) and valuing participants' understandings of the past as coherent, rational, and legitimate. With attention to the interactive moment, a good deal of confusion has emerged about *how* a therapist can honor the client's desire or lack of desire to focus on the past. ***Talk about the past always takes place in the present.*** The "rationale" for talking about the past is not, for the constructionist, to dig into the causes of the client's problem. The past need only be discussed inasmuch as the client finds relevance in telling his or her history. And, when this does, in fact, have relevance for a client, the therapist who sees psychotherapy as a process of social construction can explore how to move on from a value of the past (respect for the past) to a generative future.

What Does this Imply for the Psychotherapist?

The uncertainty that is associated with a constructionist philosophical stance is one that invites multiplicity and thereby invites therapists and clients alike to question their assumptions and explore alternative resources for personal, relational, and social transformation. We could call this *generative uncertainty*, a term that I believe echoes Wittgenstein's notion about a de-contextualized ethic when he claims, "It is clear that ethics cannot be formulated." Generative uncertainty positions therapist and client in a therapeutic relationship that is responsive to the interactive moment. The therapist is now a conversational partner and as such is free to move within the relationship in ways that enhance both therapist's and client's abilities to draw on a wide range of conversational resources. The therapist is not burdened with being "right"

but with being *present* and *responsive*. The therapist and client become accountable to each other. Yet, accountability, presence, and responsivity to each other are not enough. Our conversations in the psychotherapeutic context might be more usefully centered on community transformation. How might we, as psychotherapists, invite clients into the sorts of relationships that effectively transform our ways of living communally? To that end, social construction would suggest clinical ethics expand well beyond the therapist-client relationship.

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References

- Andersen, T. (1991) *The reflecting team: Dialogues and dialogues about the dialogues*. New York: Norton.
- Anderson, H. (1997). *Conversation, language, and possibilities: A postmodern approach to therapy*. NY: Basic Books.
- Bateson, G. (1972). *Steps to an ecology of mind*. NY: Ballentine.
- Burnham, J. (2005). Relational reflexivity: A tool for socially constructing therapeutic relationships. In C. Flaska, B. Mason and A. Perlesz (Eds.), *The space between: Experience, context and process in the therapeutic relationship*.
- Foucault, M. (1973). *Madness and civilization*. Trans. R. Howard. New York: Pantheon.
- Kelly, R. (2007). Personal communication.
- McNamee, S. (2005). Curiosity and Irreverence: Constructing Therapeutic Possibilities, *Human Systems*, 16, 75-84.
- McNamee, S. (1996). H. The Social Construction of Psychotherapy. In H. Rosen and K.T. Kuehlwein (Eds.), *Constructing Realities: Meaning-Making Perspectives for Psychotherapists*. San Francisco: Jossey-Bass Publishers, (115-137).
- McNamee, S. and Gergen, K.J. (1992). *Therapy as social construction*. London: Sage.
- McNamee, S. and Gergen, K.J. (1999). *Relational responsibility: Resources for sustainable dialogue*. Thousand Oaks, CA: Sage Publications.
- Rorty, R. (1979). *Philosophy and the mirror of nature*. Princeton: Princeton University Press.
- Sampson, E.E. (2008). *Celebrating the other*. Ohio: Taos Institute Publications.