

Pathways to Dialogue: The Work of Collaborative Therapists with Couplesⁱ

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*To hear is beautiful to those who listen.
Egyptian proverb*

Since Collaborative Therapy is often described as a philosophical position or a stance and the literature on collaborative therapy does not provide any “recipes” or steps to follow, I was interested in talking to therapists to find out how they implement collaborative ideas in their practice, specifically in their work with couples. My curiosity started when I read that many therapists believe that couple’s therapy is the hardest treatment modality and not many therapists included work with couples in their practice (Lebow, 2007). As a collaborative therapist I thought that my colleagues did work with couples, and that I worked with couple’s too and my sense was we did not feel that couple’s therapy was more difficult than our work with individuals

Abstract: *The purpose of this study was to identify the premises that guide collaborative therapists in their efforts to generate dialogues in couples. The two main research questions were: How do therapists create dialogical processes with couples? and what are the pathways to dialogue between the three members of the conversation?., Several interviews were accomplished, using a qualitative method to obtain the perspective of 10 collaborative therapists in Mexico. The main premises that emerged were: “being conversational partners”, “careful listening”, “respect”, “the couple as expert”, “genuine curiosity”, “not-knowing”, “multiplicity”, “offering without imposing”, “a process tailored to each couple’s, and “being public”. The collaborative therapist’s vision revealed how these premises are significant for creating dialogical processes with couples.*

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or families. So I wanted to find out what therapists thought about collaborative work with couples and how they actually did it. This was the beginning of my doctoral dissertation, which was a detailed qualitative study that explored therapists’ accounts of the premisesⁱⁱ that guide their collaborative therapeutic work with couples. In this paper I will not cover all of the findings of that study, but I will focus particularly on what therapist told me about how they foster or generate dialogic conversations between partners in couples.

Collaborative therapists consider conversations, relationships, and dialogical processes as their core tools (Anderson, 2007). Although a good number of therapeutic approaches are based in conversation, the task of a collaborative therapist can be distinguished for their trust of the

generative capacity of dialogueⁱⁱⁱ and the relevance of the therapeutic relationship, and not for the confidence of models and techniques in the field of psychotherapy. Other distinctions between conversational therapies would be the constant wondering of collaborative therapists about what kind of conversations generate possibilities for people, what are the ingredients of the exchanges that have the capacity for transforming the client’s life. There are other therapeutic models that work with conversations, so I wondered what are the

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therapists who consider that peoples’ problems are embedded in their language, narratives, and relationships. In this manner, therapeutic space becomes a dialogical and relational space (Gergen, 2006). The way that therapists participate in conversations and how these are built become the resources for broadening and creating possibilities: these are the central elements of the collaborative stance (Anderson, 1997).

The role of language and meaning in people’s lives is fundamental for collaborative

Biever, Bobele and North (1998) make clear that most of the dilemmas and difficulties that couples^v face, are attributed to the kind of conversations they have sustained. Thus, the task of therapists would be to establish a collaborative process as a generative space where couples can have new conversations, retake old ones, or transform them, “therapy begins by exploring clients’ unique understandings and theories about the problems that brought them to therapy” (p. 183). From this perspective, according to these authors, the nature of conversations with couples does not include the review of ‘psychological problems’, ‘diagnostic categories’, or ‘change strategies’.

Anderson (1997) suggests that it is through conversations that we form and shape our life’s experiences and events, and it is through them that we build and rebuild our realities, relationships, and ourselves. Possibilities began to emerge throughout conversations. Opportunities for the relationship are created within the dialogical process itself, and not necessarily through pre-established strategies anticipated by an author or model. The real creators for these possibilities are the members of the couple in collaboration with the therapist.

A common starting point for collaborative conversations with couples is Tom Andersen’s^{vi} inquiry about how they are going to talk from in a way they have not attempted yet. As Anderson (2000) points out, a collaborative therapist does not pretend to influence people’s stories, nor to make sense out of them, but “new ways of understanding their life struggles and relationships (...) seemed a natural consequence of this new way of talking and listening” (p. 8). Actually, questions and inquiries that therapists formulate are essential parts of the conversation, and these are based on the need to know more about what has been said or what has not been known thus far (Anderson, Carleton & Swim, 1999; Biever, Bobele & North, 1998).

Generating Dialogical Process

One of the most notable contributions of collaborative therapy with couples is the emphasis on the dialogical perspective (Anderson, 2007; Tarragona, 2006). According to Anderson (1997), the meanings and understandings of life’s experiences are created in language. Consequently, dialogue is the main vehicle of meaning and experience transformation (Anderson, 1999). Anderson (2005) suggests that dialogical processes give place to transformative conversations and change. She argues that a dialogical conversation is an active process, reciprocal, conjoint, to give and receive, to go and come back, in which people are talking with and between each other (and to themselves) more than for them (Anderson, 1999; Ibarra, 2004). As Anderson (2005) has summarized all understanding is an interpretative act and all interpretation is dialogical; thus, “dialogue is an interactive process of interpretations of interpretations” (p. 499). Therefore, new meanings and experiences take place in this process of interpretation and dialogue.

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The concept of dialogical process is found in hermeneutical philosophy and denotes, of course, one remarkable contribution to the couple’s therapy field. To understand what the dialogical process means in therapy we have to turn to the writings of the philosopher Hans George Gadamer and his illuminations on dialogical conversations (De la Cueva, 2001; Grondin, 2003; López, 2002; Monteagudo, 2009). Precisely, Gadamer (1977) sustained that “it is part of every true conversation to really attend to the other, let its perspective to be its significance” (p. 463) because “one takes the other’s place to comprehend their point of view” (p. 465).

In addition to Anderson, other authors consider dialogue, language, conversation and relationship as fundamental pieces in their work (Andersen, 1987; Hoffman, 2002; Isaacs, 1999; Penn, 2001; Seikkula, 2002). Isaacs (1999) understands dialogue as a shared inquiry process, a joint manner to think and reflect together. From this standpoint, creating something new, a thought, an idea, a decision, a behavior is a collaborative effort. Eggers (2000) declares that dialogue provides a mechanism that produces new forms of interaction. Dialogue, he says, generates the capacity for new actions and emotions because it stimulates thoughts, meanings, and horizons, opening new ways or broadening them. In another example, Anderson (2002) suggests that “dialogue is a particular kind of conversation in which participants engage with each other in a process of understanding, a process of learning how the other makes sense of something and the meaning it has to them” (p. 279).

One essential characteristic of dialogue is listening.

One essential characteristic of dialogue is listening. Dialogue implies a profound and respectful listening to all the expressed perspectives within a conversation (Isaac, 1999). In this sense, the collaborative therapist learns to listen carefully with respect and genuine curiosity to couples' words, statements, and ideas (Biever, Bobele & North, 1998). Seikkula (2002) argues that the best dialogue is that in which one feels that he/she has learnt something. In fact, he considers that crises are characterized by monologues. The therapist does not have a predetermined agenda that exactly dictates in advance, which questions and steps will be accomplished during the session (Seikkula, 2002). Instead, Seikkula focuses his therapeutic efforts on generating dialogue between people who participate in conversations and his personal challenge is to figure out how to create a language in which everyone's voice is heard.

Virtues of Collaborative Work with Couples

Collaborative therapists are concerned with situating the client at the center of the process instead of on the margins, in giving the therapeutic relationship substantial weight, in generating careful listening and in creating a generative dialogical process (Ibarra, 2004). One of the trademarks that stand out in collaborative therapists' work is their interest in achieving an excellent therapeutic alliance with clients. Aside of the lack of empirical study about the impact of collaborative practice in therapeutic relationships, there are several authors that qualitatively report clients' satisfaction with this kind of therapeutic process. Clients confirm that they feel listened to, respected, and that their point of view has been taken into account (Gehart-Brooks & Lyle, 1999; London, Ruiz & Gargollo, 1998). Clients perceive their collaborative therapist as warm, close, and genuinely interested in them. Surely this is due to the fact that the collaborative stance sets out that the goals and means of therapy should be constructed and established in close partnership with clients.

Based on the ideas of Anderson (1997) and Tarragona (2006), we can say that collaborative therapists: a) work from a non-pathologizing stance; b) appreciate and respect the couples' reality, and the individuality of each member; c) value the couples' "local knowledge"; d) respect the couples' views about their dilemma and pay attention to the ideas they generate during the conversation; e) are very interested in trying to understand the couples' life from their perspective; f) make use of all of the couples' knowledge about their life, problems, stories, solutions, and goals; g) consider couples as experts in the topics that need to be discussed; h) respect the point of view of each partner; i) are "public" or "clear" about their biases and information; and j) are flexible regarding the use the length of the therapeutic process, respecting a couple's decision as to when they want to see their therapist and when they want to stop the therapy conversations.

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Finally, according to Lebow (2007), there is no technique or model that is best or more adequate for a population with the same dilemma. From his point of view, particular therapies cannot be applied to a particular set of problems as it is not

very effective for dealing with patients' unique problems. Lebow further argues that one therapy is not necessarily better than another as each problem has an individual combination of factors that will impact its efficacy depending on the circumstances. In this sense, the collaborative approach reveals another advantage: as it does not follow a strict model or technique, every client and his or her situation is seen as unique and every process is "tailor made" (Anderson, 1997).

Process of Inquiry

The purpose of this study was to inquire about how collaborative therapists describe their premises of their collaborative stance and philosophy and how they think these may allow the generation of dialogical processes in their work with couples. The methodological strategy that I used for this research integrated different approaches in *qualitative research* in the field (Creswell, 1998, 2009; Kvale, 1996; Moustakas, 1994; Strauss & Corbin, 1990; Taylor & Bogdan, 1987).

Participants

Ten psychotherapists who practice in Mexico City and who work from a collaborative stance with couples were invited to participate in this study. The therapists were gathered to participate using a *purposive sampling* process (Creswell, 1998; Patton, 1990). Patton (1990) described *purposive sampling* as the selection of participants according

to their individual characteristics. Initially, the author invited twenty collaborative therapists who lived in Mexico City, via e-mail or by telephone. Since I have been a collaborative therapist myself for many years, I was able to get in touch with several therapists who fit the desirable profile for my research project. Nevertheless, I just selected those therapists that met these basic criteria: 1) Having therapeutic practice with couples, 2) Having a specialized training in collaborative therapy, and 3) Identifying themselves as collaborative therapists. After the initial contact, ten therapists met these criteria and were willing to participate.

Nine of the ten participants were women and one was a man. Their ages ranged from 35 to 54. Two participants were single and the other eight had been married for an average of 23 years. The nationalities of the ten participants were: eight are Mexican, one Mexican-Uruguayan, and one Argentinean. In terms of education, seven had masters' degrees, and three had doctorates. They had an average of 13 years of experience working with couples.

On average, the participants said they would describe themselves as *collaborative therapist* for 10 years. They had trained in collaborative therapy for an average of was 9.4 years. One therapist estimated working with the collaborative stance 60% of the time, two estimated 80% and seven estimated 90% of the time.

Data Collection

Data was collected using *qualitative interviews* since they are an excellent way to obtain data through dialogue and conversation (Kvale, 1996). I attempted to get the perspectives of collaborative therapists who work with couples, as expressed in their own words and understandings (Creswell, 1998; Kvale, 1996; Taylor & Bogdan, 1987). Qualitative interviews have the capability to collect in-depth, detailed and rich descriptions (Patton, 1990). I used a General Interview Guide (See Appendix A) which has a set of basic inquiries that were explored with each participant (Creswell, 1998; Moustakas, 1994). The Interview Guide was based on 1) The main and secondary's objectives of the research (asking myself what kind of questions could help to accomplish those goals); 2) My curiosities in this project (what did I need to talk about with the therapists in order to grasp their pathways to dialogue from their perspective); and 3) The literature (how the literature has discussed this topic so the interview guide could explore it in a different way and the results could enhance our knowledge of this subject).

Once I had the first interview guide, I presented it to ten judges (eight colleagues and two professors from my doctoral program). I asked the judges if they thought the Interview Guide was could to obtain the information that would accomplish my research objectives. I made some adjustments to the guide based on the judges' feedback and created the final version of it. I then proceeded to interview the ten collaborative therapists. I did, 25 interviews, which varied in length from of 60 to 180 minutes. All conversations were digitally recorded and a total 32 hours and 42 minutes of material were collected and produced 310 pages of transcriptions. I believe that theoretical saturation was accomplished with all of the participants (Creswell, 1998; Kvale, 1996; Patton, 1990).

During the first meeting, the participant and researcher read and signed an Informed Consent Form and answered a Participant Identification Form that included some of the most important characteristics that defined them as collaborative therapists. All participated on a voluntary basis and no one was paid for taking part in this project

Data Analysis

I analyzed the data following the qualitative data analysis methods of different authors (Creswell, 1998, 2009; Gehart & Lyle, 1999; Gehart, Ratliff & Lyle, 2001; Kvale, 1996; Moustakas, 1994; Strauss & Corbin, 1990; Taylor & Bogdan, 1987). However, the author that had the greatest influence on my analysis of 310 pages of transcripts was Clark Moustakas. He has a phenomenological view, which for this study meant to understand collaborative therapists' thoughts, to respect their individual experiences, to elucidate their view. My aim was to analyze, organize and convert their descriptions into emerging categories based on the therapists' own words. I wanted to respect their individual experiences while transforming them into a broader explanation of collaborative work with couples and the part that therapists play in the generation of dialogues in therapy. This is why I chose to present the results as a "unified whole", presenting the answers of different therapists as one voice without losing the essence of their individual experiences.

Following Moustakas' (1994) phenomenological analysis approach, the main categories of analysis about how collaborative therapists facilitate dialogical processes, emerged from the therapists' own words, from their

understandings, and from their theories and thoughts about working collaboratively with couples. In other words, the name of each category or “premise” was obtained from the therapists’ descriptions, not from the theory, nor from an author. I processed the data in five steps: 1) *Reducing the data*: I read the 310 pages of transcripts several times to eliminate those descriptions (data) that did not answer the research questions. I only kept those descriptions that were directly related to the purpose of this study; 2) *Identifying categories*: I read these descriptions several times in order to identify the emerging categories, in this case the therapists’ descriptions about the premises of collaborative work that help them as a therapist in the creation of the dialogical processes with couples; 3) *Grouping of verbatim excerpts*: after I identified twelve premises, I grouped all of the information under the premise it belonged to.; 4) *Presentation of the ideas*: once all the verbatim excerpts were grouped in their categories, I re-read the therapists’ descriptions of their guiding premises to decide how to present them. In this step I had to decide how to introduce to the reader each premise, which idea or definition first, which ones at the end of each premise.; 5) *Writing the results*: I considered several options for presenting the results of the study. First, for this project, it was not important to know “who has said what”. I thought it was viable to use only “one narrator”, “one entity”. I chose to use a metonymic style about “the collaborative therapist” working with couples. So, it was unnecessary to use pseudonyms or numbers for the participants –as used in traditional qualitative reports. Second, as a qualitative research teacher, I do not like qualitative reports that have too many verbatim quotes in their results section. So I decided that for each emerging therapeutic premise I would only include one or two verbatim excerpts at the most. Third, the rich and inclusive therapists’ visions that the participants offered could be assembled into “the collaborative therapist”, since most descriptions could work for any of the therapists in the group. With this in mind, I thought that the reader could understand and grasp the pathways for generating dialogue with couples better if I unified the “voice” of the participants as one voice. The entity of “the collaborative therapist” brings together all the knowledge, topics, examples, and explanations that I analyzed from the transcripts from ten collaborative therapists. The results do not contain my experience, explanation, or vision. My goal in using this style was to communicate the collaborative therapists’ shared experience as one entity, avoiding an ‘individual understanding’ format.

Triangulation

Triangulation is one of the most used strategies to secure internal validity in a research project (Creswell, 2009; Moustakas, 1994; Patton, 1990). For this study, I used two triangulation strategies A) *Theoretical triangulation*. Once the results were concluded, I went back to the literature on collaborative theory to corroborate if the results explained the ways of generating dialogue between people in the same way the theory does. I found that Harlene Anderson’s text, *Dialogue: People creating meaning with each other and finding ways to go on* (2007) is a flourishing theoretical approach that converged very well with the perspectives of the therapists who were part of this study, and B) *Participant triangulation*. At the end of my data analysis I invited three participants to verify that their perspectives and understandings were properly synthesized and presented in the results; that is, if the results correctly embodied their work with couples. The basic goal was to verify with participants if the results were valid and the data was properly analyzed. One Format for Participant’s Verification (See Appendix B) was sent via e-mail along with the results. The three participants reported that the results described accurately how they work with couples and included their vision about how to generate dialogue with them.

Twelve Paths for Grasping Dialogue

I found that the ways in which therapists described how they foster dialogue in couples’ therapy could be organized into twelve emerging categories. They are:

I. Being Conversational Partners

Being conversational partners is constructing a conjoint space. The therapist does not go into the session with specific steps about what he/she is going to do with the couple, in which sequence, and which actions he or she will take. On the contrary, the therapist arrives with the great disposition to construct the therapeutic process with “a little of what they bring, a little of what I bring, plus a little of what the encounter brings.” The therapist does not impose topics, ideas, tasks, suggestions, or actions for transformation and change. The therapist assumes a more horizontal stance during the therapeutic process but he/she does not adopt a passive manner. Each member of the conversation contributes their knowledge, thoughts, and actions to the process.

One of the ways to facilitate the opening of a dialogue with couples is through the establishment of agreements about how the general therapeutic process will be managed between the three (the therapist and the couple), beginning with the basics on how the sessions will be conducted such as the regularity and frequency, who is coming to the encounters, and especially what are the goals of the process. I do not impose all the rules. The couple needs to feel that they are part of a team or community.

Being conversational partners makes couples feel comfortable and then willing to share their thoughts. The couple initiates a dialogic process when they feel taken into account, respected, and included. They say what they want and what they don't want. The therapist shows a genuine interest for each person's ideas, perspectives, and suggestions. The therapist is authentically interested in what is happening to each of them, what they are living, feeling, and thinking. "It is like putting oneself at their service", trust what they are saying they need, and not only in what the therapist believes is good for them. The therapist helps the couple to reach the place "where they want to be, what they want to achieve". One of the most asked questions is what needs to happen for this space to be worthwhile, as a way of helping the couples identify their individual and joint goals.

When the couple has different objectives, for example, if one wants to be together and the other wants to separate it as hard and painful, consequently, generating dialogue becomes a big challenge. A good conversation leads them to listen to each other, and to acquire more tools that will help them to adjust and make decisions. The pain that is present in the therapeutic space does not remain outside of their conversations. Neither does the process aim at having one member persuade the other to stay in the relationship. Quite the opposite, the collaborative therapist tries to confirm if the subject of the conversation is actually the topic that they need or want to talk about.

I can ask them if what we are talking about it is useful. That allows me to work on the topics that are based on their interests and not the topics that are important for certain authors or models. To have a conversation about what they want to discuss helps to generate dialogue. To talk about theoretical or methodological issues closes the dialogue. Couples arrive with their own ideas and concerns that do not necessarily relate to the "family of origin." I accompany the couples through the things they need at that moment and in that conversation.

The therapist can have his/her own concerns, but he/she should try not to let them enter into the conversation. To participate *per se* is not an action that helps to generate the dialogical process. It is necessary to create a bridge that links the couple's and the therapist's agendas. The therapist can propose his/her ideas but the couple decides if those subjects are relevant for the conversation. Something that could be significant for the therapist might not be crucial for the couple: "the therapist should learn to let go of his/her worries when he needs to do so". This is not to imply that the therapeutic goal always comes from the therapist's side. Occasionally, the therapist can suggest their own topics for discussion and, when the couple agrees, they can be discussed.

Therapy becomes a process where everybody learns. It is a challenge since some couples would like to be offered precise formulas: "we need you to tell us what we have to do to function in a healthy way". The couple determines what themes or actions are necessary to improve in their relationship within the same dialogical process. Being conversational partners is a premise that develops from the idea that that the therapist is a temporary partner that has been invited into couples' life.

II. Careful Listening

"Careful listening" is listening to couples from a non-judging, non-criticizing, non-evaluating, curious and active stance. This is one of most important premises that help to generate the dialogical process.. Listening means understanding, learning, and changing. When the members of the couple do not feel judged, they are encouraged to dialogue. The therapist is receptive to what each member has to say. *Careful listening* generates a dialogical and reflective moment. Dialogue implies *careful listening*. This premise is the mainstay for generating dialogue; without listening and speaking there is no dialogue

The therapist role is to really listen to what they are saying to you. I mean, I don't listen to them from a theoretical framework, like others models usually do, because listening to them from a theory is not really listening. It is necessary to stop interpretations, or fitting them in to

certain hypothesis or classifications. Theoretical concepts could be very useful but can also be a hindrance, if the therapist says in conversation with them “of course, I know what you are talking about, and it confirms to me that you are a codependent couple”. Well, it is evident that the therapist stopped listening to them without noticing when.

It is vital to listen to what the couple wants to share. Thus, therapists make an additional effort to put their ideas to the side, not in the middle. That does not mean that the therapist should rule out, remove, or ignore those ideas. He/she should try to put them to the side to be able to *listen carefully*. When the therapist doesn't listen because he/she is interpreting, classifying, or making hypotheses he is not helping the dialogical process. That is because his/her participation and questions are then only used for confirmation.

The therapist's collaborative stance pays attention to what the couple has to say and how they want to say it. The therapist listens to what the couple is trying to communicate and tries not to influence them with preconceived ideas. It is a stance that makes the emphasis on listening to couples by “trying pure listening which entails not mixing, not invading and, not imposing ideas but allows the couple to really listen to each other and what they want to express”. It is avoiding a trap in which the therapist only expresses his/her opinions, knowledge, and theoretical conclusions: “that would be a monologue and that is disinviting to the dialogue”.

It is a premise that invites us to listen to the couple from their point of view. There is not a right or wrong way to express ideas. It is necessary to be careful and respectful when listening to the couple. I ask them if they feel listened to, if they feel that we are talking about the topics that matter to them. One important part of listening is that the therapist listens to their self and that each member of the couple listens to themselves. Like Harry Goolishian and Harlene Anderson said, oftentimes we don't know what we think until we put our thoughts into words. That is very important.

The therapeutic space is about generating a dialogical process where couples have the opportunity to learn what they think about certain subjects, such as whether or not something is hurting them, if they are willing to change their perspectives, their decisions, or behavior. The therapist is there, devoted to listening, being with them and being interested in everything they are saying.

During the first encounter the therapist could let the couple set up two monologues or do the things that could generate dialogue. This means that the therapist's role is not about passive listening. It is not only listening considerably about how one part of the couple complains about the other. To enable a space for two monologues does not help the couple to feel heard. *Careful listening* makes it possible to notice the finer points, those not considered, not thought or not yet included.

III. Respect

Respect denotes that the therapist is a guest in the couple's life. When someone is a guest, he/she behaves with respect, trying not to be intrusive or critical. The position from which the therapist asks or makes remarks is very respectful like a guest in a conversation.. One of the therapists' guides for this premise is the idea of being a momentary guest in the couple's conversations. Another is the therapist's awareness that what he/she says or does will have an impact on the couple's relationship.

The *respect* premise can also be noticed through the therapist's acceptance of the couple's decisions. It is the couple's privilege to make the crucial decisions in their relationship such as living together, not living together, separation, or divorce. During conversations the therapist's language demonstrates the *respect* premise. It is not an expert language, “where I tell the couple what they have to do and how to do it, some therapists, from other models, do not ask the couple if they are able to do what is suggested, if a suggestion makes sense to them, if the suggested task asked is viable, etc.”. The collaborative therapist respects the couple's language, their stories, descriptions, emotions, dilemmas, possibilities, and resources, throughout the process without criticizing, judging, censoring or disqualifying them. It is when the couple feels respected that dialogue appears. The therapist respects the boundary fixed by the couple that allows him/her to enter in their lives. As a result, the therapist makes his/her suggestions from a position that allows the couple to decide what to take and what is useful for them. The *respect* premise helps the therapist to develop a satisfactory connection and a good therapeutic relationship. It is in this kind of relationship that dialogue can occur.

Another form that the *respect* premise takes is checking with the couple to insure that the process is being helpful, that both feel included and that they have been able to talk about what is important to each of them. The therapist also confirms that the couple is looking at their life and relationship from another angle and that new possibilities are being created for them.

Part of the *respect* premise, in Collaborative Therapy, comes from Kenneth Gergen's social-constructionist philosophy, in relation to the question of absolute truth... the therapist does not tell the couple whether they are right or wrong, if what they do is correct or incorrect, or whether the way they interact is functional or dysfunctional. What the couple is telling you is not being judged, from your stance and you are careful of the words and ideas that you express. What each person in the relationship says is equally important. It is not about finding who is right and who one is wrong.

For collaborative therapists it is important to know or to be trained in other ways of working with couples and other therapeutic methods in general. However, the difference between the collaborative therapist and other therapist in general is that the collaborative therapist brings those models and different tools to his/her work making use of the *respect* premise and the whole collaborative stance. The challenge for the collaborative therapist is how to include or implement those models and tools. "All techniques are considered useful and encourage the creation of new possibilities but they are not implemented indiscriminately for all couples". The therapist first considers the couple's own stories, narratives, needs, goals and experiences. As each couple is unique with their own distinctiveness and particular characteristics, different process are created with each of them.

IV. The Couple as Expert

Each couple is viewed by the therapist as an expert in creating possibilities and the partners are considered as experts in their difficulties, stories, life, experiences, and solutions. The therapist's stance is being a partner in the conversation who collaborates with them to achieve what they want to attain. One of the ideas that helps facilitate the generation of dialogue is that every participant in the conversation should feel that his/her voice is equally important and valuable.

Couples are experts in knowing all the details of their stories and are able to explain what they are going through and what they are feeling. Since they know what is happening in their life, they can describe what has worked for them and what has not. The therapist can know a part of the dilemma and some versions of the story, and is able to develop successful conversations about different topics relating to the dilemma; however, the therapist should not take for granted that he knows better than the couple what ought to be done in order to resolve the dilemma. The therapist works with them, in collaboration, to find the pathways to dialogue, the pathway that will bring transformation. As they are considered 'experts', the therapist should offer his/her ideas tentatively, trying not to favor them.

From postmodern philosophy, it is difficult to presume that there is only one way to facilitate change in couples and assume that this single way could be imparted from a particular author, model or therapist. On the contrary, the collaborative therapist believes that all techniques, tools, ideas, and initiatives, offer interesting methods but they are only considered suggestions. The collaborative therapist measures the need and importance of these tools. The therapist gives priority to the couple's ideas and to what emerges during the process. The therapist trusts that couples can find different ways to approach their problems. In that sense, the therapist is an expert in generating conversations in which couples can find or develop their own possibilities, "I am a facilitator of the means to find or identify their abilities or to optimize them". As couples have all the experience and knowledge about their relationship, that experience is taken into account, it is important and it is not rejected during the conversation. Everything they know about themselves being a couple, everything they have shared and lived together is especially valuable.

Talking about how do I look at myself as couple therapist...? I see myself as a facilitator of communication, conversational, and relational processes, but I don't look at myself as an expert in how couples needs to be or act. I look at myself as a facilitator in process of change, generative processes that can help couples -as experts in their relationship- to find different ways to relate.

As a couple, they are experts in the direction they would like to take and what sort of decisions they want to make. Most therapists are very well trained in psychotherapy, couples therapy, psychotherapy research, couples and marriage theories, and all that can be used in the therapy room. However there is no need to disregard everything that couples know or prefer. The ideas can come from anywhere and they are not offered with absolute authority because that looks down on the couples' self-knowledge and experiences. The collaborative therapist avoids the imposition of any model of how to be in a relationship or how to be a couple, "they are experts in their unique model of how to be a couple, and that model can constantly be reconstructed, reconsidered, or modified".

V. *Genuine Curiosity*

The stance of genuine curiosity comes from the authentic interest in couples, their stories, narratives, language, and meanings. The therapist can explore the topic of their choice and carefully inquire into these situations and shared moments. *Genuine curiosity* favors dialogical processes because it is in those places where alternative stories, new possibilities, and diverse explanations can emerge. The stance of genuine curiosity's stays away from talking about the same things or repeating conversations they have already had between themselves or with other people. This premise leads to the creation of different language and meanings, and new narratives and perspectives. One pathway to open dialogue in couples is through a respectful curiosity and a legitimate interest. "It is like getting into what they are saying". The therapist makes sure to understand what they are saying, "do not take anything for granted". *Genuine curiosity* is a desire to know more about the couple's own ideas, meanings, understandings, and views. "Trying not to presume that I understand what they want to tell me. I try not to lose sight of what they mean".

A way in which you can practice this premise is in the detailed and attentive exploration of the couple's stories. I go slowly; I have so much interest in their meanings and their accounts. This curiosity is to show a genuine interest in the couple, wishing to know about each of them. It is not knowing just for knowing like gossip, but to know in order to help and to open possibilities and alternatives with the aim of opening dialogue and so that each of them can better appreciate how the other sees things and how the other understands the situation. The purpose is to awaken in couples a genuine interest for the point of view of the other, a desire to know more and to suppose less.

The therapist's inquiries start from curiosity in what the couple says and offers.. It is not a curiosity about getting answers to some hypothesis. It is not an evaluative curiosity. Questions that emerge from this curiosity do not include judgments or critiques; they are questions that do not attempt to discover the true story or the precise facts. When the therapist favors one version, he stops being curious. The curiosity can come, for example, from the *not-knowing* position, and the idea of not taking the story for granted. The inquiry comes from the therapist's curiosity in relation to the conversation he is having with the couple or from a past conversation with them. The purpose of curiosity is to help the couple to reach their own goals. It emerges from the conversation itself and as a consequence of the legitimate interest in the couple.

Genuine curiosity implies the desire to learn from the couple and to figure out how they look at each other. "Some of the couple's problems start when they assume they know what the other means, they misinterpret the other's actions, or they presuppose that they know what the other wants". Therefore, this *genuine curiosity* is also an invitation for them to listen to each other from a different place, a place not yet explored. The premise *genuine curiosity* helps to develop dialogical processes since it contributes to a constant search for new knowledge, understandings and comprehensions that will eventually allow the couple to resolve their dilemmas or to find possible solutions. The *genuine curiosity* premise contributes to a constant reflection.

A modern therapist could presume many things or establish diagnosis; they can take for granted what the clients' words mean. Instead, for example, if the husband says that she is depressed, the postmodern therapist explores the words meanings and shows curiosity "What do you mean by depression? How it feels to be depressed?" It is to show interest to enter into the couple's own language, to understand their meanings, what does it mean to the person and for the couple. To show interest in the impact that it has for the person and for the couple.

Usually, the questions that come from a good number of theoretical and clinical models are "managed" questions. Instead, questions should emerge from the conversation itself, "it should not be questions 'to prove', for example if

they are a <codependent> couple. They are not questions to generate a moment of “insight”. They are not questions that you know will lead the couple to a certain conclusion”.

VI. Not-knowing

The collaborative therapist does not presume to know what is ‘ideal’ for the specific couple with whom he/she is talking; and will not lead them to a ‘correct’, ‘functional’ or ‘best’ model to be in couple or in relationship. The collaborative therapist does not believe that there is one way to be a couple, or that one way is better than another. Neither does the therapist believe that there is an ideal pattern for couples or a preferred pattern for a relationship. “Some authors maintain that there is an ideal family structure that is functional, integrated, and healthy. What is the optimum model for a ‘functional’ couple?” The collaborative therapist does not search for a particular kind of relationship to attain, “each couple has unique qualities, distinctive to that couple; and in that sense, they have to learn and discover the better way to be in the relationship, to understand each other, the way to be a couple with their own characteristics”. Each couple has the challenge and the opportunity to build their own model with its own style of functioning. The therapist adopts a stance of *not-knowing* what is the couple’s normal, ideal, functional model. The *not-knowing* premise implies to not know the perfect way to be a couple.

Consequently, the collaborative therapist does not attempt to impose on the couple a model that dictates to them how to act in order to function well as a couple. In order to generate dialogical processes with couples, it is important that they feel recognized for having a unique style, different from all the other couples in the world. The couple already knows how they can be better, or they will inform themselves through these dialogical processes. The *not-knowing* premise means, among other things, that the therapist does not know *a priori* how they should be as a couple. It is within the therapeutic process that they will find out where paths to progress will be better generated.

The *not-knowing* implies a move away from theoretical or cultural ideals. To me, there is nothing other than their own understanding of what it means to be in couple. As I start from not knowing *a priori* how they should be, I engage in the task of building this together throughout the therapeutic sessions.

The *not-knowing* position persistently allows exploring or asking questions that may bring new options for the couple. The *not-knowing* stance helps to inquire from a different place. It allows the therapist to be more curious, “the not-knowing situates the couple in a place where they are able to better listen, understand, and know points of view that they have not yet considered”. The collaborative therapist does not consider him/herself an expert in others lives. Thus, they do not know what would be best for the couple because “they are the experts and they know better what they want or what will be useful”.

VII. Language Oriented

The collaborative therapist considers language as relational and generative. Consequently, the role of language in collaborative therapy with couples is especially important to generate dialogical processes. Notably, *language* determines the way in which we relate, “that’s why, to me, it is so relevant to understand and comprehend how the couple uses language, to also explore how the couple has created their own language and meanings, and in which part of their language or meanings they are blocked, or do not flow when trying to communicate”.

The philosophers of language maintain that nothing exists outside of language, we are immersed all the time in language and all our experiences take place or are shaped in it. The therapist works with *language*. When therapists intervene with couples, the actions, feelings, thoughts, ideas, and emotions are brought and reconstructed with *language*. *Language* is the cornerstone for collaborative therapy. Language is the major tool to know another person in a literal or symbolic sense for all modes of expression. The couple desires to know and learn a lot from and about the other. Different things that they are not what they are used to seeing or hearing at home.

The collaborative therapist’s language is careful and includes the *respect* premise. It is not an imposed language. What is offered through language is presented as one option among several. *Language* includes anecdotes, points of view from literature, programs, research, authors, theories, but they all go through a filter that puts the ideas into a more colloquial, simple, and quotidian language. The *language* also takes a tentative form. Since every experience can have

a different form for each member of the couple, the therapist must attempt to tentatively share his/her ideas and that is also what helps to open dialogue because “there are not absolutes. These are not impositions. The couple could not listen to the therapist if he makes assertions such as ‘all men’, ‘all unfaithful’, ‘what you should do is this...’”.

The other side of the therapist’s language is that it tends, over time, to blend with the couple’s language. The collaborative therapist starts using their words without a strategic intention but to facilitate dialogue or “to talk from the same track. I am very careful with the couple’s language, how it is used in their stories. I try to use their speech, to talk with the same language they are bringing to the conversation”. Now and then each member has their own language and meanings, “sometimes I use one, sometimes the other one. In the end, they have become aware that they may have assumed some meanings that weren’t exactly those of their partner. On one occasion I used the whole session to explore what it meant for her that he had paid more attention to her”. The collaborative therapist frequently asks about meanings and language uses, “the goal is to find a language in which the three of us understand better”. In other words, it is clarifying the ideas, elucidating meanings, and understanding words.

VIII. *Diagnosis*

“One ingredient of dialogue is to look at people as they wish to be seen”, therefore each member of the couple describe themselves and want to be seen in a particular manner. As a result, the collaborative therapist is not listening with the purpose of obtaining a diagnosis. Nevertheless, the couple can bring their diagnoses, labels, and classifications from elsewhere. The aim is to try to understand what they mean to the couple, how they were named, and they appeared. The therapist’s work is not from a pathological view and it does not focus on shortcomings. When the couple arrives to the therapeutic room with a diagnosis the first endeavor is to clarify it.

Some therapists can suggest a *diagnosis* during the conversation as a concern, just to verify that it makes sense to them, and it is shared from a respectful place or tentative manner, “look, what is happening to him could have some of the elements of a condition called depression. Does that make sense to you? What do you know about depression?” During the conversation the therapist can inform the couple about his/her own ideas about a certain diagnosis but the couple might not agree with them.

The collaborative therapist avoids making a *diagnosis* to any part of the couple, “I don’t tell them ‘you have “depression”’ or ‘your wife has is a “generalized anxiety disorder”’. Instead, the therapist can open a dialogue talking about the impact that the diagnosis might have on them. The employment of a diagnosis is mostly a way to explore meanings, “a couple once came and she was diagnosed with “bipolar disorder”. What I did was to explore what they thought about that diagnosis? How did this diagnosis change their lives? What were the effects? What did they do with this?”

Another form in which *diagnosis* is employed to open dialogue is having a conversation about what the definition in the DSM-IV says. The therapist can explore whether or not the experiences the couple is having are related to those portrayed by the psychological community. The collaborative therapist in fact considers “the achievements and merits of modern psychology, what it has taught and the benefits it has shown, although all the contributions pass through the stance, the key is how to employ a diagnosis, it is not just about ignoring it, what you try to avoid is labeling people”.

The idea of offering a diagnosis is not penalized, simply, it is first considered for working with the exceptions, resources, stories, alternatives, affirmations and successes, or people’s competencies, etc. If one were to think that a specific session was going to be the only session with the couple, what would one employ in that conversation? It is surely not very helpful for couples to leave with a diagnosis such as “we are a <codependent couple”. They probably do not benefit that much.

Repeatedly, when the therapist offers a diagnosis to the couple, or one part of the couple, they stop listening since their inner conversation speeds up, thinking about the latest adopted diagnosis. “Some authors consider that working from a pathology discourse to be counterproductive, in the sense that it can maintain the problem”, instead collaborative therapist works with their resources and offers possibilities. In the perspective of collaborative therapists, pathological language freezes the conversation, taking away the movement, and the intent to continue the inquiry gradually stops. Some couples even arrive to the therapeutic space with a diagnosis that was not be established by a professional. Perhaps the couple develops the diagnosis themselves, sometimes it is the influence of a friend, or it comes from the poor use of literature, from the Internet, or from local culture.

When a couple arrives with a label, for example “we are a codependent couple”. I feel a lot of interest in knowing the meaning and the story associated with that word or concept. To explore these meanings is a way to generate dialogue. In that sense, one of the objectives is to explore what does the diagnosis or classification mean for them? What does “psychological violence”, “being codependent”, or “destructive relationship” mean?

To manage the dialogue it might be necessary to not assume the couple’s meaning about their actions, concepts, or words. “It is about having a conversation concerning what does it mean for the couple or for the relationship to have a certain diagnosis or label? How have they managed what they say they are? What is the impact of having this idea?” The diagnosis is something that reveals their experience and understanding. The therapist may have a conversation with them about the utility of the diagnosis. Has it been helpful to the relationship? Does it have a purpose? Do they find it convenient if they find another way to describe their problem? Sometimes, a diagnosis can be useful as a possible explanation for what is happening between them- “A couple told me that the <bipolar disorder> diagnosis was very helpful for them because they could finally put a little order in their chaotic world”.

The therapist, when conversing with the couple can also identify a diagnosis as described in the DSM-IV. In that case, when the therapist has the opportunity to place it in the conversation it is done as a personal concern or in a tentative manner to see if that diagnosis makes sense to the couple. “In case the diagnosis does not make sense, you disregard it; instead of believing that they are in a denial or opposition”. The aim is to converse in a different way about the diagnosis, not exactly in the pathological way but with a more optimistic approach. It is not to paralyze the couple but to recognize their resources for confronting the problem. When the therapist works with the pathological approach it is in order to deconstruct the meaning of it. There is an important difference talking about pathology versus resources.

IX. Multiplicity

The multiplicity premise that facilitates the dialogical processes is evident when the therapists bring all of their various areas of experience and knowledge into the conversation. These ideas can come from books, authors, colleagues, movies, literature, history, metaphors, friends, their own experiences, from other psychotherapeutic models or anything that might be relevant in relation to what the couple is bringing to conversation. When the therapist believes that an idea from their experience is relevant to the process he/she may utilize it in the conversation. The collaborative therapist looks for multiplicity in conversations or experiences. As there is more than one way to see a problem, there is also more than one solution. The multiplicity premise does not necessarily look for a couple’s consensus, “unless that is part of what they want to attain”.

Another variation of the *multiplicity* premise when working with couples is the postmodern idea of multiple realities or that there are different ways to see the world and to experience things. Problems can emerge when there is a belief that there is only one way to see things or that there is only one reality with one way to explain their lives, relationships, and actions. It is important for generating a dialogical process to engender either multiple perspectives or understandings in the couple. This premise allows them to work with tolerance, flexibility, or the acceptance of different versions of things. To consider that there is one valid explanation of an experience can be an obstacle for the relationship. It is a challenge for the therapist to be able to see different angles.

Although in psychotherapy it is thought that couple’s therapy is one of the most difficult challenges, the collaborative therapist assumes that three people instead of two in a conversation can improve in the process.

In couple’s therapy the work is more interesting, I mean that there are more heads, more ideas; the fact that there are more people makes it easy to generate more questions and more options. When working with couples everybody is enriched as ideas come and go, bounce, rebound, come back, and travel. There are more ideas, more questions, more discussions and more possibilities are generated.

The *multiplicity* premise includes different points of view that have not yet been considered. “In conversation the couple realizes that there is not one single version but there is also the other’s version and sometimes both versions can coexist”. Respect is also considered, respect for the other’s perspective. Therefore, the therapist may find that as a result of the couple’s acceptance that there are multiple ways of seeing things and that each is entitled to think

differently. When the couple recognizes that the therapist's intention is not to impose the views of one of them they are willing to open themselves up to dialogue.

X. Offering without Imposing

Offering without imposing is a premise that refers to what the therapist says to the couple, which emerges from the conversation itself and the comments are brought into the conversation as an invitation or offering. It is not an imposition or obligation. This premise can be different from other psychotherapy models. The collaborative therapist avoids telling couples what they should or must do, and what they offer is not said as "I am telling you because I am the expert". Possibilities come out during the conversation and emerge from the same participants.

As a participant in the conversation I give my ideas, but I offer them as extra ideas to the conversation. It is not an imposition from my side, or a guideline that should be accomplished because I am the expert. It is simply an idea that I have and that I would like to share with them and then check with them to see if it makes sense or not, if it is useful, or if they want to try it. The couple has the last word concerning the ideas that I offer them.

Offering without imposing is considered an ingredient that facilitates the dialogical process because the members of the couple are willing to open their inner dialogues and reflect when they do not the imposition of the other person's ideas. *Offering without imposing* allows the possibility of disagreement and being able to talk about it. "This week, I suggested to a couple that they might make some space for themselves as a couple, that maybe it was not necessary to be always surrounded by friends. She said that my comment made sense to her, that she missed when they used to go out together for dinner. The therapist's ideas are not imposed, they are suggested as 'in my opinion, maybe you could...'"

Now and then, the collaborative therapist can offer ideas that come from other approaches or models in psychotherapy. "Once I told them that I had read an article that said meditating and breathing deeply several times a day was helpful to reducing anxiety and stress. I asked them if they were interested in learning breathing techniques so they could apply them during the week and then check to see if they are useful" The therapist can also offer personal experiences or information that they have read and ideas that have been useful to other couples. "The couple can decide whether to take them or leave them".

XI. Tailor Made Process

More than working with couples from a specific model or couple's therapy technique, the collaborative therapist works with the collaborative philosophy and stance. Consequently, each process is different with every couple, whereas the kind of conversation is the same. For example, there is no requirement for working with both members of the couple. The therapist can receive them together or individually. It depends on the case, the situation, and what the couple wants. There is no requirement to work with both people in order to achieve changes and reach their goals. Nor is it a necessity that couples separate for some sessions. The decision is up to them, their expectations, and the themes that are emerging. The collaborative approach is not a model most therapists are used to. The therapist attempts to go where the couple asks to go.

During the first session with the couple the goal that brought them to therapy can be defined, as well as their personal objectives and expectations from therapy. It could be during the conversation that the frequency of the sessions and attendance are established. Each process and each couple is different. No two processes are identical because the specifics of each encounter are defined throughout the conversation. *Each couple's process is tailor made.* There is not an invariable strategy for conversational themes. "It was not essential to talk about family of origin, emotions, or behaviors, as they said they had done in other therapeutic experiences". The therapist does not know *a priori* which topics to talk about with the couple. That is why it is called *tailor made*. The couple decides what they want to talk about and sets their own goals.

Sometimes you talk about the past, sometimes about the future, and sometimes about the positive aspects of the relationship. Each case is different. I don't anticipate the themes I am going to discuss with each couple. In some ways, I am a guide for them in their own search, using the language they employ. I don't arrive with a preconceived idea about what I am

going to do in the session. You have to tailor the session according to the assessment of each couple.

The couple gives some keys to the therapist. All the therapist's questions are elaborated for that particular couple. The therapist does not have an interview guide, assignments, or strategies to be implemented with all the couples they work with. What the therapist has is a trunk, sack, or pile of experience and knowledge that they take out according each couple's needs and the specifics the relationship.

I like to look at myself as having a little sack that contains all my techniques; and according to comes up in the conversation, the themes they share and what is happening during the session. I take out my questions, exercises, authors, or strategies, everything I have in that little sack and I start to use them in the conversation.

The collaborative therapist talks about what the couple brings to therapy - their present concern. To focus on the current dilemmas of each conversation is an invitation for dialogue. When the couple would like to talk about a certain subject but the therapist changes the subject the dialogical process can be closed. The *couple's tailored process* is a premise that can be noticed when the collaborative therapist checks with the couple to see whether or not the conversation is useful and how they feel the process is going. Hence, this process is always open to the inclusion of new elements during the conversation or even to change the direction of therapy.

XII. Being Public

Being public implies that the collaborative therapist shares his/her ideas, knowledge, experiences, opinions, wonders, or feelings with the couple. It is all about contributing to the conversation with new ideas and different perspectives that might be helpful to the couple. The therapist follows some criteria in order to *be public*. First, what the therapist is going to share should be considered as positive and useful for the couple. Second, the therapist should be comfortable with the information he is using during the conversation. With open dialogue "the couple feels that the therapist does not have a hidden agenda. What the therapist is thinking or reflecting is not a mystery. The therapist demonstrates him/herself as being an active participant in the conversation".

The therapist can share what he is thinking, his/her inner dialogue with the couple; and the couple decides if they want to keep the idea or reject it. The intent of offering of the therapist's ideas comes from the genuine ambition to help and to support the couple and the conversation. *Being public* is not only showing transparency. The crucial question is how and when to do it. Certainly, there will be times that the therapist shows, with all respect, a less tentative opinion such as when the topics concern abuse or violence.

Being public can be understood as:

...as playing with open cards and sometimes telling the couple what comes to mind. If I recognize violence I name it so that it can be more useful to them. It is not like my own catharsis. I have cried with them. I allow myself to show what I feel. I have held back my tears when facing the death of a couple's child. It happens to me in relation to the profound pain of the couple but also as regards their happiness. If a particular event is important to them I like to rejoice with them.

The therapist's thoughts, reflections, or feelings, can be established in the conversation too. It is difficult to have a compass that indicates if it will be useful for the couple, but it would be a loss not to offer them, "I share anecdotes, my own experiences; all that I believe could be of service to the couple. I make it clear that it is my personal view and that they are not obliged to see or act as I do".

I may mention to them authors, strategies, statistics, research, or my political stance, "look, in my opinion..." What I do is to contextualize my opinion. I make clear that it is my own point of view, "I do not agree with spanking the kids, since nothing justifies violence. I don't believe that 'spanking' works with children..." I prefer to set limits with other options as <these> or <those>, literature says..."

Being public also makes reference to the moment in which the therapists talk about his/her worries about what he is hearing, “this last couple I saw made me think that they were at a great risk of hurting each other”. Accordingly, the therapist may *be public* regarding his/her worries about the present possibility risk. Or, the therapist can bring out all the possibilities that the couple has not yet evaluated. “I also may tell them that we need to consult another professional in a different discipline, and I explain to them why I consider; for example, that we need to get a psychiatrist’s point of view”.

Implications for Therapy and for Life

This project emerged from my curiosity about how therapists generate dialogical processes when working with couples. As collaborative therapists consider collaborative relationships and dialogical conversations as the main vehicles to initiate the transformational process of solving, resolving or dissolving persons’ dilemmas (Anderson, 2007), I chose to do this study using qualitative interviews to inquiry about how they achieve this. However, for future studies, I think it will be more interesting 1) to include collaborative therapists from different countries and training places; 2) to tape the work of collaborative therapist working with couples and discuss with colleagues what pathways to achieve dialogue they see in the session; 3) to analyze the work of other therapeutic models that generate dialogue too.

When working with couples, the therapist assumes the collaborative stance and philosophy, and change is expected as a natural consequence of the kind of generative conversations produced during the therapeutic process. From this understanding, therapists in Mexico City who work with couples view the application of the collaborative stance and philosophy themselves as the primary pathways for generating dialogical process. It became clear that more examples of this are needed and to include more illustrations from the therapists voices.

However, the reader can have a good idea about which elements collaborative therapists consider as the main core of dialogue. In other words, the reader will have the main premises that collaborative therapists considered as the pathways for dialogue. Some questions emerge, as what is the nature of these elements from the collaborative stance that generate dialogue in a couple? What is the nature of each premise? For example, what do therapists do in order to not appear as imposing? What is the respect’s nature that makes it different from the ‘respect’ that all models and orientation assume? The results from this project bring a lot of questions that have not been answered, so they leave a lot of future projects for the field.

The aim of this study was not to understand what dialogical processes, but to find out how the therapist generates and reaches them within the therapeutic space. In that sense, the results show that this goal was achieved. The data analysis pointed out that categories such as *being conversational partners*, *careful listening*, *respect*, *the couple as expert*, *genuine curiosity*, *not-knowing*, *language oriented*, *diagnosis*, *multiplicity*, *offering without imposing*, *couple’s tailored process*, and *being public*, are the main pathways to reach dialogue according to therapists’ understandings, and as literature has pointed out (Anderson, Carleton, & Swim, 1999; Seikkula, 2003). Certainly, these results may seem to be quite familiar to collaborative practitioners; however this project is an effort to get the pathways for dialogue not from a theoretical standpoint but from an inquiry process with the therapists themselves, who ultimately are the ones who have the challenge to generate dialogue with couples in their clinical practice. Although it was attempted to fill the gap between just conceptualizing how to generate dialogue or define the collaborative premises, and look inside how the therapists achieve this, it is clear that a different process of inquiry will be necessary to deepen this endeavor.

This qualitative study has different implications for psychotherapy practice with couples. First, the principal therapeutic approach in couple’s therapy insist in the need of developing well structured models and techniques to intervene with couples. However, the results of this study confirm the importance of creating a tailored therapeutic process for each couple. Second, this collaborative perspective establishes the foundation to inquire more about the importance of matching the therapeutic goal to each couple. The *not-knowing* premise, understood for therapist as ‘not-know’ which is the ideal model for being part of, related to, or living as a couple, leaves us with something to think about.

According to most of the interviewed therapists, to open a dialogue it is fundamental that the couple feel comfortable in the therapeutic space. From their perspective, there are several situations that may hinder the dialogical process. The couple may feel criticized or judged if the therapist imposes all the rules, goals, themes or topics to be discussed or if

the therapist's knowledge, hypotheses or interpretations are not offered but forced through monological discourse, or if the therapist does not listen carefully and fit the couple's stories within their theoretical framework. Instead, the collaborative therapists identifies that there are some elements that invite the dialogical processes, such as establishing a space in which every person feels like a conversational partner, or through the therapist's genuine curiosity and interest for the couple's stories, descriptions, and meanings.

Among the benefits of this project, I found that most collaborative therapists noticed the importance that research interviews had for them, since they could understand, clarify, and elucidate, their work with couples. Most of the participating collaborative therapists told me that they found a better understanding of the kind of therapeutic processes they construct with couples, as the result of being interviewed. It is important to point out that even though collaborative therapists believe that they do not change their philosophy or stance when generating dialogical processes with individuals, couples, families, or groups for this project, they tried very hard to identify which were the specific premises employed when working with couples, and in which manner these facilitated the generation of dialogue between them. Perhaps the results of this study could seem very modest or just relevant for collaborative therapists; however, they aim to be a contribution for any therapist, from any therapeutic orientation, who works with couples. Finally, one major objective of this project is to be able to make the work of collaborative therapists in Mexico, their philosophy, premises and stance, known.

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APPENDIX A. GENERAL INTERVIEW GUIDE

I. About the therapeutic process

1. How do you describe your work, the therapeutic process, with couples? What do you do?
2. Is there something that we have not conversed about that describes how you do work with couples?

II. About the collaborative philosophy and stance

1. Which are the collaborative premises most employed in your work with couples?
2. With which collaborative premises, ideas, or concepts do you work with couples? Could you explain me one, another, another...
3. How do you make use of those and implement them in clinical practice?
4. Could you give me an example of how do you use premise X? Another... another...
5. How do you take into practice the collaborative idea about (...)?
6. Which are the therapeutic tools that you implement the most working with couples?
7. Do you find any variation in the collaborative concepts' implementation when working with couples in comparison with individuals, families, or groups? If you make any difference please explain in which manner?

III. About the dialogical processes

1. How do you generate dialogical processes in your work with couples?
2. How do you achieve the dialogical experience with the couple?
3. Which collaborative therapy premises help you to facilitate the dialogical process with couples?
4. Which are the approaches you employ to generate dialogue?
5. Which are the strategies you employ to generate new meanings? (Negotiate, deconstruct, explore, create new meanings or language)

APPENDIX B. PARTICIPANT'S VERIFICATION FORMAT

INTRODUCTION

The purpose of this format is to verify if the results describe adequately your experience.
Thank you for your participation.

1. The results presented to you, describe adequately your work with couples? (If your answer is "yes", please go to the next question. If your answer is "no", please explain your opinion).
2. The results presented to you, agree with your perspective about which are the main collaborative therapy premises and approaches used for you in your work with couples? (If your answer is "yes", please go to the next question. If your answer is "no", please explain your opinion).

3. The results that you have read include your vision about which are the different collaborative possibilities in the work with couples? (If your answer is “no”, please explain your opinion)

Endnotes

ⁱ This work is based on Monica Sesma’s doctoral dissertation in the Universidad de las Americas, A. C. The author would like to thank Luis Alvarez Colin, Ph. D., Andromeda Valencia Ortiz, Ph. D., and Blanca Garcia, Ph. D. for their collaboration. I am especially thankful to Robert H. Roop, MBA and Maria Grunberger, MBA for their collaboration with the English version.

ⁱⁱ Since collaborative practices do not consist of specific “techniques” or strategies, collaborative work can be done in different ways. This is why I chose to concentrate on the “premises” or ideas that therapists identify as the guiding principles of their work with couples.

ⁱⁱⁱ Among this work, we can conceptualize *dialogue* as Harlene Anderson defined it “Dialogue is an interactive process of interpretation of interpretation” (Anderson, 2005, p. 499); or “Dialogue is a particular kind of conversation in which participants engage with each other in a process of understanding, a process of learning how the other makes sense of something and the meaning it has to them” (Anderson, 2002, p. 279).

^{iv} In American literature, the collaborative approach is also identified as *Collaborative Language Systems*. In this article ‘collaborative approach’ will be understood as the long trajectory of Harlene Anderson from the Houston Galveston Institute, their past and present collaborators, and the authors that have been using her ideas in psychotherapy.

^v I find Biever, Bobele and North (1998) definition of “couple” very useful for the purpose of this article. They conceptualized couple as “two people involved in a committed romantic relationship who share a household, a history and a planned future” (p. 182). In addition, to me, a “couple” is an entity of two people who consider themselves as couple.

^{vi} Norwegian psychiatrist, author of *The reflecting team: Dialogues and dialogues about the dialogues*. His ideas have influenced Harlene Anderson’s collaborative philosophy and he is one of the recognized postmodern therapists in the family therapy field.

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