



# Family Therapy as a Process of Humanisation: The Contribution and Creativity of Dialogism

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Family therapy shaped by the twin contributions of radical humanism (after Freire) and dialogism together create a binocular vision for practice. This vision encompasses the intricacies of moment to moment responses that are seen to occur within a politically informed and socially structured relational context. The breadth of practice possibilities shows no allegiance to any particular 'school' of family therapy but rather advocates for an orientation that humanises the relationship between therapist and family. This humanising orientation counters 'technologies' of practice that reduce the social or relational complexity of human existence creating categories of deficiency or pathology that individualise distress. Practical applications of aspects of dialogism are described and illustrated with a focus on multi-actor participation and attention to embodied responsiveness by the therapist. An attitude that encourages joint experimentation, serious playfulness and the 'performative' are offered as examples of the scope of a dialogically informed humanising practice. In addition practice challenges are considered, in particular where contexts of power 'over' the other are a necessary part of one's professional context.

**Keywords:** humanisation, creativity, dialogism, practical considerations, aesthetics

Dialogue cannot exist without humility

Paulo Freire

## Pass It On . . .

When a traditional folk musician describes the piece of music he or she is about to play the likely introduction will include references to earlier interpretations of the tune, its origins and its location in time and place. The music's form of delivery and features will be described as well as others' musical interpretations. The performer thus places his or her rendition within a historical stream of influences. The tune will have evolved with each interpretation, and each influence will be acknowledged as part of the musical legacy about to be passed on to the next generation of musicians. It is not so much a history lesson, more a mark of respect for the music and the musician's interpretation of its spirit.

So too with family therapy. You may find the characteristics of a dialogical orientation, to be described in this paper, are in sympathy and synchrony with your existing practice orientation, and value base, as they have been with mine (Wilson, 1998, 2007). In addition to these heartening coincidences and sympathetic rhythms, I hope to describe how dialogism and related ideas can stimulate and enhance development as therapists still further.

In considering family therapy as a process of humanisation, my aim is to show examples and acknowledge ideas for you to use in ways that inspire and suit your practice style in your own work context.

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### **Style is unique**

I recently presented a clip of my family therapy practice to a workshop audience, including a number of philosophers. My co-presenter mentioned that some of the practice on view could be described as Bakhtinian in certain respects. A workshop member questioned this by saying that a truly Bakhtinian approach would have changed the course of the interview in a more Bakhtinian direction. I wasn't at all sure what he meant and found myself saying, 'But this isn't Bakhtinian therapy . . . It's Wilsonian therapy!'

This was a light-hearted episode but there is an important point to be made. Each of us will have navigated through many schools of thought, many contexts of theoretical, personal and professional influences, so we are always in the process of becoming (Holzman, 2009). Our personal style as a practitioner is unique and each influence has ultimately to be embodied through our dealings in life with others. Seikkula and Arnkil (2014) make the point that dialogicity is 'to be experienced, not grasped cognitively and learned as a technical skill' (p. 193).

### **A brief account of connections**

So it is important to try to see where the influential springs and tributaries of earlier family therapy have merged to create a flow of ideas and practices that now also include a dialogical orientation. A dialogical orientation is not a new school or a fixed set of procedures for dialogical practice (though some tips are helpful). It is more a culmination of influences that have contributed to considering family therapy as a process of humanisation and further exploration of what can be useful and effective in steering the craft of family therapy and associated practices along new rivers of creativity.

When the *Open Network for Dialogical Practices* was established in 2010, each of the formative members (Justine van Lawick, Peter Rober, Jaakko Seikkula, John Shotter and the author) wished to acknowledge influences on our practice of different therapists and their orientations, in particular the work of Gianfranco Cecchin (1987 and Cecchin, Lane and Ray (1992, 1994)), Michael White (2011 and White and Epston, 1990), and Tom Andersen (1991). These therapists elaborated practices that were informed differentially by systemic theories, social constructionism, and narrative approaches and the philosophical writings of Foucault, Derrida and Wittgenstein amongst others. These wellsprings of influence carried ideas to us along with all our prior experiences in studying and practising family therapy over many years.

### **Humanisation and dialogism: A preferred stance**

The therapist/practitioner places open responsiveness to others' contributions as a central tenet of practice. This means resisting the drive to categorise, to place oneself as an expert above the other (though neither should we eschew knowledge and experience that might be useful), or to respond to the other as object.

In practice this orientation translates into a more transparent process whereby the practitioner is not only curious about another person's life but openly engages as a human being who is also a professional helper. The focus of a democratically shaped dialogical orientation is on the other's responses and resources as a guide to the direction of the family therapy session. The emphasis is on valuing the contribution of many participant 'voices' in the ongoing dialogical flow. One aim is to try to keep theories and ideas in mind whilst encouraging the movement of thought and action in more spontaneous ways. However, this general orientation is easier to state than to practise.

We are schooled in ways of creating explanations, looking for causes, trying to influence the other through directives, strategies and giving (un)invited advice. When worries overtake us it is more difficult to be reflexive, responsive, and facilitative. Instead we can all resort to default positions, digging in our heels and creating eddies of repeated unproductive exchanges.

In *Pedagogy of the Oppressed*, Brazilian educationalist Paulo Freire (1996, 1998) describes the process of humanisation as a person's growing awareness of his or her participation in the life that comes with the challenge to make choices that free them from oppression without replicating patterns that oppress others. Radical humanising practices affirm human beings as the subjects, rather than the objects, of decision making: 'It is absolutely essential that the oppressed participate in the revolutionary process with an increasingly critical awareness of their role as Subjects of the transformation' (p. 108).

Transposing this ideal into family therapy promotes opportunities for critical reflexivity and action through which all participants transform potentially oppressive practices in therapy into creative possibilities. The opposite process, dehumanisation, is expressed in self-subjugation, acts of cruelty, injustice and exploitation. In mental health services such injustices are revealed in 'top-down' practices, reducing complex social dis-ease to singular diagnoses, where social stressors are viewed as personal deficiencies and, more insidiously, where self-subjugation has eroded personal agency (Wilson, 2013). Dehumanising processes deny dialogue and the consciousness of the other.

Therapy as a process of humanisation is unavoidably a social and political activity aimed at countering oppressive practices. In addition, ideas from dialogism can enrich the intimate detail of family therapy practice congruent with a humanising orientation.

The following illustrations and practical considerations<sup>1</sup> offer ideas to shine a brighter light on the nature of our attempts to create a practice that is 'imbued with a profound trust in people and their creative power.' (Freire, p. 56) It is also a practice that avoids objectifying, 'top-down' ways of meeting with families in therapy.

## **Practical Considerations**

### **We are not talking heads**

It is impossible not to have influence; when we meet with the others in practice it is impossible not to feel something; tiredness, pleasure, care for the other, sympathy and so on. It is impossible not to have thoughts – 'She looks tired ... he is looking cautious ... she is welcoming'; it is equally impossible not to respond.

Tom Andersen makes the distinction summarised in Seikkula and Arnkil (2014) of three different forms of reality that invite different responses in communication. The first is the *either/or reality* where definitions are made and remain fixed irrespective of context. The second is the *both/and reality* in which many simultaneous descriptions are possible. This is a familiar orientation for family therapists. Thirdly, is the *neither/nor reality* where we experience something taking place, 'but do not have an exact linguistic description for it' (p. 112). This realm of the undefinable momentary connection is considered by Stern (2004): 'The basic assumption is that change is based on lived experience. In and of itself verbally understanding, explaining or

narrating something is not sufficient to bring about change . . . An event must be lived with feelings and actions taking place in real time, in the real world, with real people in a moment of presentness' (p. xiii).

We are multi-sensorial beings and our connections with others benefit from attending to moment by moment responsiveness in the proximity of a family therapy session. These sensed similarities (Shotter, 2013) do not constitute hypotheses; rather they are the stuff (associations, impressions, memories, feelings) of potential connection and exploration to be savoured rather than rushing to find explanations that leave the present moment behind: 'We forget that there is a difference between meaning in the sense of understanding enough to explain it and experiencing something more and more deeply' (Stern, 2004, p. 140). When Andersen spoke of his response to the experience of a handshake he was neither searching for a definitive explanation nor representational meaning. Instead he allowed for the deepening of experience in the silent connection between participants perhaps acknowledged in a responsive gesture but largely left without words.

### **Focus on moments that matter**

The therapist has to be on the lookout for those moments that hint at some novel occurrence. For dialogue to have therapeutic potential it requires to be charged by an appreciation by those involved to respond sensitively to the 'fleeting hints' in expression and behaviour that signal something new and different is taking place (John Shotter, pers. comm.). We need to register and respond to this beginning as a sign of fresh possibility in the conversation.

In practice, however, such moments may go unnoticed, especially if therapists are thinking too far ahead, with too much intention, or organised by bureaucratic concerns about following a prescribed procedure. Such temptations squeeze the life out of dialogue and this is sensed by family members as a disconnection in the relationship with a therapist. The therapist's skill is to notice what is happening here and now where special significance may be afforded apparently ordinary words, the utterance of which may hint at a new expression and fresh direction in the dialogue. Here the so called 'banal' words acquire special significance, perhaps voiced for the first time, perhaps said before but with less authenticity, perhaps now heard by the other in an illuminating way. The therapist is focused on each nuance, each small move, and each impression.

Stern (2004) sees such a moment as, 'the coming into being of a new state of things, and it happens in a moment of awareness. It has its own boundaries and escapes or transcends the passage of linear time . . . [I]t is a moment of opportunity when events demand action or are propitious for . . . [I]t is a moment of opportunity when events demand action or are propitious for . . . Events have come together in this moment and the meeting enters awareness such that action must be taken now . . . be it for the next minute or a lifetime' (p. 7).

### **A turning point**

Bill and Sue are in a couple session to discuss their daughter's aggressive behaviour towards family members, especially her father. At a certain moment Bill talks of his impulse to hit his teenage daughter during a recent explosive argument saying, 'I held her by the hair . . . I could have hit her . . . then I looked into her eyes and I saw myself looking up at my father . . .' (He puts his head in his hands and begins to cry and his wife comforts him.) My response was to say, 'This is a turning point . . .'

To try to capture the depth of this experience would require Proustian attention to detail and still it would not be adequate. The realisation that Bill was about to repeat his father's violence towards him stopped him in his track and at the same time I sensed he saw me notice his struggle to express himself. This momentary exchange between us held a weight of gravity and revelation. His was not so much a confession as a plea to be accepted in his painful recollections. The moment called for a 'matter of fact-ness' that acknowledged the painful event unfolding as he spoke and as I listened the words in response formed: 'This is a turning point . . .'

This is not a pronouncement I would usually make but I found myself trying to find words to reflect the importance of his courage. His heart-felt statement was met with my heart-felt opinion. And somewhere at the door of the therapy room I could hear other ideas knocking to come in. The importance of the 'not yet said,' the concept of therapy as ritual transition, the emergence of intersubjective consciousness, the Bakhtinian idea that knowing oneself is only possible by seeing oneself through the eyes of the other. But I left them outside until later.

A dialogically oriented practice presupposes that all dialogue is open-ended, 'unfinalisable,' and when views are subordinated to a single or monological perspective only single truths prevail. So, in the above example, the work with Bill and Sue continues and at the time of writing the therapy has taken new directions and will soon end by mutual agreement. However, all three participants agree the moment we learned of Bill's fear of striking his daughter carried a special quality: that of a turning point.

### **Avoid monological entrapment**

According to Bakhtin, 'Monologism at its extreme denies the existence outside itself of another consciousness with equal rights and equal responsibilities . . . [W]ith a monologic approach . . . another person remains wholly and merely an object of consciousness, and not another consciousness' (Bakhtin, in Irving & Young, 2002, p. 22). According to Irving and Young (2002), Bakhtinian dialogicity is open ended, 'To live means to participate in dialogue: to ask questions, to heed, to respond, to agree and so forth. In this dialogue a person participates wholly and throughout his whole life: with his eyes, lips, hands, soul spirit, with his whole body and deeds. He invests his entire self in discourse and this discourse enters into the dialogic fabric of human life, into the world symposium' (Bakhtin, 1984 in Irving & Young, 2002 p. 22).

When our minds are cluttered with explanatory theories, or preoccupied with other concerns it is understandable that we are tempted to fall back on certainties: truths about a matter and the like. 'Research suggests such and such . . . This problem responds better to CBT . . . We need to take control of the risky behaviour and do a risk assessment now!' None of these responses are in themselves problematic but if they are upheld as generic truths fired by the practitioner's anxiety, the results can be damaging and sometimes dangerous. This lack of critical self-reflexivity tends to objectify the other and closes the door on transformative dialogue. Instead our endeavours create defensive monologues. No one is listening.

### **Promote 'aesthetic practices and safety'**

Educationalist Sir Ken Robinson contrasts anaesthetic educational practices with more aesthetic qualities. This analogue has direct relevance for practice informed by a dialogical orientation in family therapy. The anaesthetic model in therapy is

characterised by routinised activities and techniques, akin to an industrial model whereby standardised methods are taught, and expertise is held within a hierarchically organised system. The recipients of such expert knowledge and intervention are fed through a 'banking' system of education (after Freire, 1996, p. 53) where what is taught is intended to make up for the deficiencies of the learner (or client in the case of therapy). This deficiency oriented practice dulls creativity and open participation.

In contrast aesthetic qualities in therapy and education draw from an organic model whereby divergent thinking is encouraged together with the active celebration of experimentation and an appreciation of many possible directions and outcomes in the meeting with the family. This wider participatory and resource-focused orientation allows for a broad repertoire of possibilities in the performance of practice (Wilson, 2007). A dialogical orientation celebrates the polyphony of voices with aesthetic qualities taking precedence over the pre-planned and formulaic.

That said, we also need directions of a sort to help us to create a safe enough structure within which we can improvise, just as a musician needs to know the key to play in and the general form of the piece to be played. Providing basic frameworks for theorising and the development of a safe enough context for learning are necessary requirements in training. However, over-reliance on technique and planning is counterproductive as this restricts attention to the unique detail of each encounter.

Shotter (2006) proposes that preparation is necessary in readying oneself for the forthcoming meeting. This is in order to 'warm up' so to speak; to aid thinking and consider how one may position oneself to be alert and open to the others when we meet. This is in contrast to planning, which is a predetermined act of organisation that attempts to stage the forthcoming meeting along certain lines of enquiry. Responsiveness is not the prime focus, rather the aim is to follow a party line in a somewhat mechanical performance of practice.

When participants in a family therapy context feel safe enough to improvise then spontaneous responses become more available. This is sensed, rather than measured. John Shotter emphasises the capacities of participants in dialogue to be considered, 'spontaneous responsive living beings intimately connected to our surroundings ... [that] open possibilities for action guiding anticipations' (pers. comm.). Here the therapist's response invites a fresh opening, a creative risk towards something as yet unknown. This is where we are not so much allied to a theory or a model but to sensed similarities evoked in the ongoing flow of dialogue in the session. These cannot be adequately described through reason alone.

While each context offers creative possibilities it also has its limitations. It is therefore important for therapists and clients to be mindful of what seems possible rather than pursuing utopian solutions to complex problems.

### **Do what is possible**

The attempt to avoid predetermined ideas about how therapy will proceed creates a challenge. How might we engage with the unknown without being overwhelmed and lost in the multiplicity of relational events in a family therapy session?

In practice this requires the therapist to be able to play with uncertainties, yet offer direction when the context calls for it, or take a 'back seat' when the session spins into some useful exchange without their direct involvement. I enter the family

therapy session having studied and practised for many years so I am not a blank screen. I am, however, always on the lookout for ‘falling in love’ with one way of seeing (after Gianfranco Cecchin, pers. comm.), or feeling convinced or indignant that my view is better than the others. Hubris is the killer of diversity. I try to enter without prejudice and learn instead to notice the others’ responses, and my responses to them. In the emergent process of a session I experiment with ways of engaging – moving, opening themes, addressing the mood of the session, exploring possible directions – but I am always anchored in what are the main aims and wishes of the clients.

All my prior studies and practice sit expectantly beside me. *It is the manner of meeting that signifies a humanising attitude to practice.* Useful ideas from Structural, Narrative and Post-Milan approaches may come to the fore but they are mediated and shaped by an attitude and philosophy toward practice as a process of humanisation described here. No idea is redundant if it can be of therapeutic use within any given context.

These are my efforts to create forms of dialogue that, in Gergen’s words, ‘attempt to cross the boundaries of meaning, that locate fissures in the taken for granted realities of the disputants, that restore the potentials for multi-being and most importantly, that enable participants to generate a new and more promising domain of shared meaning’ (Gergen, 2009, p. 193).

### **Performative Aspects of Humanising Practice**

The illustration that follows aims to elucidate these ideas in family therapy practice in order to open new possibilities for a family. In this session, the family, together with a small team of family therapists, joined to create a new context as I had reached a blind alley in my thinking about how to be of assistance. The example draws on systemic and dialogical influences to illustrate the weaving of humanising practices into a co-operative endeavour.

Richard and his son Paul (16 years) have come for two family therapy sessions already but the tone of each session has been marked by their constant criticism of the other. In recent months Richard’s teenage daughter Pip has come to live with them and this has added to the tensions in the household. Pip did not arrive for this session.

### **Play Back therapy**

A note of explanation. *Playback Theatre* is a form of creative improvisational theatre in which audience participation provides the stories or anecdotes that are offered to the acting company who ‘play back’ the story transformed through dramatic portrayal. In the playing back, elements of the story are characterised and a sensitive, perhaps exaggerated or humorous depiction of the story is offered. The playback theatre creates a vivid visualisation of a narrative in ways that the audience participant feels the story has been magnified and enriched by the improvisational performance. Something new has been offered and witnessed in a containing context.

Play Back therapy emerged as an idea inspired by taking part in a Playback Theatre session some months earlier. Play Back therapy contains some of the improvisational qualities of Playback Theatre but is shaped as a therapeutic endeavour to assist

all participants. Whilst prior studies and experience affect the form of the improvised Play Back therapy outlined below, the stages of the therapy were not imposed on participants but negotiated at the outset as an ‘experiment.’

### **The therapist’s quandary and team discussion: Proposing multi actor dialogue**

In the pre session meeting I talk with my colleagues about my sense of not getting very far. I explain that Richard wants suggestions about what to do with his oppositional and aggressive son and Paul wants his father to ‘get a life.’ It seems that when all three of us are in the therapy room it is almost impossible to break the cycle of mutual complaint and criticism, and when I’ve tried to offer suggestions they have fallen on deaf ears. Each of them is wedded to their point of view and neither is in a position to step back to be open to alternatives. I feel lost as to what to do. My colleagues in the family therapy team share their views about how to connect more usefully and we play with the idea drawn from Playback Theatre. The suggestion is that instead of bringing the father and son directly into the usual family session we could perhaps meet to discuss an experiment to help us to find ways to be of better service to the family. We decide that I should conduct the session along the following lines assuming of course that Richard and Paul are open to the idea. Here is a sketch of the session that followed.

### **Stage 1: Discussing the idea of Play Back therapy with the family – Making transparent the therapist’s quandary**

My quandary and proposal are discussed with Richard and Paul. The suggestion was made that a therapy team member would first ‘team up’ with a nominated family member to get a, ‘picture of your wishes for your family and your views on what is the matter that concerns you.’ The interviews are loosely structured in order to gain an appreciation of each family member’s version of his situation at home. As the daughter Pip, is not present, one team member offered to improvise her position so she could be ‘present’ too.

The following stages were described to Richard and Paul and after a slightly surprised reaction from father and son they agree to give it a try.

### **Stage 2: ‘Pairing up’: An appreciative exploration – Attending to embodied responsiveness in the story told**

The pairing up session allows for a closer appreciation of the individual family member’s position and creates a working alliance with the ‘paired up’ therapist to portray the family member’s views sensitively and respectfully. In addition to what is discussed the ‘paired up’ therapist may begin to sense possible themes that are ‘not yet said’ but somehow implicit in the one to one discussions. These are the nuances that point perhaps to a more creative and novel dialogue between participants that may emerge in the Play Back session to follow.

The ‘paired up’ therapist tries to create a rounded rather than a flat characterisation of the family member (after Forster, 1962) by entering the portrayal of the family member with particular attention to embodied responses that emerge as the ‘paired up’ therapist asks and listens to the family member’s responses. This is where the ‘inner talks’ of the therapist try to create a sympathetic rhythm with the family member they will represent. The therapist is therefore portraying the family member’s position without instructional intent. Rather the therapist attempts to enter the logic



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of the family member's views and experience. This provides the 'material' to be portrayed in the forthcoming Play Back session.

### **Stage 3: The Play Back session – Entertaining play and uncertainty**

The team members are then asked to enter a characterisation of the family member they will portray. This characterisation carries both an intellectual appreciation of the chosen family member's views and, crucially, a keen attention to the feelings evoked in the earlier pairing up session. This is where each therapist will use their sensitivity based on the pairing up session to anticipate and judge how to portray and enhance the family member's views and experience. This is a delicate matter because there is a risk of exposing feelings or views not ready for discussion. The therapist needs to use skill in judging what is possible to contribute so that it does not become a 'too unusual difference' (after Andersen).

The Play Back family is interviewed by me whilst the real family members become my team behind the one way mirror. They are invited to watch me interview the characterised family members and later to meet me with their opinions, reflections and above all their critical appraisal of the portrayals. The family members observe and experience the playback as participant observers who have a crucial role in the development of ideas and possible directions for any future therapy.

The shape of the interview cannot be overly structured. The 'actors' offer their portrayals of family members in response to my questions about their experience of the therapy so far and their expectations about the next possible steps. Once the play begins I am interviewing in a way that takes account of my embodied responses. I am taking each moment for 'real,' where each response from a character informs the next response from me. This is a 'real' interview in which the characters are, of course, also playing themselves. This is serious play in action. Following the Play Back session the family members are invited in from behind the one way mirror to offer their responses.

### **Stage 4: Family as observing team offer responses – An opportunity to see oneself in the eyes of the other**

The playback session is revelatory for both Richard and Paul. Each had sat in engrossed silence behind the one way screen. Both Richard and Paul identified with their character fully. In addition both agreed that they had not until now been able to appreciate Pip's position in joining the family. Both father and son had found a way to be in fresh supportive dialogue with each other. Richard commented that he could see that he had been pushing his son too hard to make 'a good life' and Paul was more aware and appreciative of his father's desire to make a better life for his family. Both father and son were visibly moved by the witnessing of the teams portrayal. 'I don't feel alone,' said Richard. 'We hadn't really thought about Pip's feelings in joining us.' Paul looked pensive and it felt appropriate for me not to pursue their reflections further but to let them be.

### **Stage 5: Family and team share learning and impressions – Communing the conversation**

The therapy team members and the family join together. Each therapy team member is invited to say what they learned *for themselves*. This focus keeps attention on the team members' learning and *reduces* any temptation to talk further about the family members. In so doing it balances the power relationships to some extent by focusing

on our mutual learning. In this example each therapist was able to talk about a feeling they had that reminded them of an aspect of their own learning in their personal lives. One team member remarked how his way of trying to be a father meant at times he tried too hard. The team member playing Paul stated that he too wanted to 'get it right' and thought maybe Paul was also doing this in his family. The female therapist playing Pip said how she felt inspired by the way Paul and Richard were open to each other's point of view. This was new learning for her about how new ways can be found to generate useful dialogue in her practice.

This is an example of application of performative practice in family therapy (Wilson, 2007) that resonates with Bakhtin's concept of dialogism, that 'compels difference, uncertainty, playfulness, surprise and open-endedness as necessary, positive and productive aspects of the human condition' (Irving & Young, 2002, p. 19). This playfulness includes irreverence (after Cecchin) and a willingness to 'playfully mock, and carnivalise our cherished ideas, to generate a freedom to recognise and seize opportunities – what Bakhtin called 'porous moments' in which we can create newer forms of the profession in practice' (Irving & Young, 2002, p. 20). Therapy is an improvisation where the one way mirror acts as a proscenium arch rather than an evaluative objectivising scaffold.

In the above example the usual hierarchy was playfully reversed. The family became the team. The team became a characterisation of the family and the family members were always afforded the last word. It felt safe enough to improvise. I had felt stuck. The playback therapy session freed me, my team and the family to find new possibilities in our meeting. The therapy had become a dialogical team effort.

### **Considering Challenges to Humanising and Dialogically Oriented Practices**

The above practice illustrations are taken from my work as a Consultant Systemic Psychotherapist in the National Health Service in the UK. This is a role that affords me much professional autonomy to organise and facilitate opportunities to work freely with the clients and colleagues involved. Yet there is a challenge placed before practitioners where statutory practice require therapists, social care and mental health professionals, to take action opposed by family members (such as safeguarding children who may be taken away from parents). What then are the challenges for a humanising and dialogically oriented practice?

A humanising orientation to family therapy is not a set of techniques or a concern with expertly driven truths but is appreciative of, and entertained by, uncertainty, a focus on complexity and a desire to place oneself as far as possible as a facilitator within the conversational flow. This is termed 'with-ness talk' by John Shotter (2010), a preferred position compared to the objectification that takes place when people are addressed in dehumanising ways. In talking *about* the other, the danger lurks that, handled without a humanising orientation, the recipient will become the object of the practitioner's judgement.

The attempt at openness and transparency by the professional helper in such a contested situation may be construed by fearful family members as a sign of weakness or false friendliness. Whilst necessary dialogues may continue in the complex multi-actor context of a child welfare agency they can be experienced as monological objectifications by those family members whose voices are silenced and whose opinions are negated.

Here the practitioner/therapist is organised by having to operate within an inspectorial context where *power over* the other replaces *power with* the other at that specific time. Yet even here, where the humanising ethic of practice is tested to the limit, it can also find solid foundation. It is at times when the acts of the other – threats of violence, rage towards the therapist or expressions of hatred – put the therapist's back against the wall (sometimes literally) that the reflexive practitioner's practical wisdom comes to the fore. The therapist/practitioner needs to hold fast to treating the other as a human being worthy of respect whilst attempting to enact a duty of care towards those involved. This is based on our moral reasoning through which, we, 'Blend appeals to principles, rules, rights, virtues passions analogies, paradigms [and] narratives ...' (Beauchamp & Childress in Banks, 2006, p. 68). Dialogue does not stand outside ethical considerations.

Some years ago as a newly qualified social worker I had the painful task of receiving children into care who were later placed for adoption. Our team had tried long and hard to work to rehabilitate the children with their parents but nothing seemed to help. The children were admitted to hospital having been given a deliberate overdose of medication by their mother. The learning from this case has stayed with me. How is it possible to respect the complexity of the parents' lives, their human sensibilities whilst being part of a decision making process that took away their rights as parents? Each time I met with the parents over the following two years, I endured their anger and hatred towards me and all that social work intervention represented to them in their disempowerment. However, Jane, the mother, taught me that we could remain in touch despite her opposition towards me and in time a feeling of mutual respect grew between us.

To persist in a practice that refuses to objectify the other is at the heart of therapy as a human dialogical process even when we are, of necessity, in direct opposition over fundamental matters of care and protection.

### **Returning to Currents of Influence**

When Lynn Hoffman (2002) came to the end of her historical journey in tracking over 50 years of family therapy's developments, she described contemporary family therapy as 'performative,' referencing the work of Newman and Holzman (1996) as well as those communal social practices of which dialogism is an expression. In this article I have sought to show how practice informed by dialogism is in sympathy with an approach to family therapy that is inspired by co-operative, politically democratic and humanising principles. These approaches are inevitably part of the evolution of practice in our search to 'fail better.' The innovations steered and pursued by Van Lawick (2012), Seikkula (in Seikkula and Trimble, 2005, Seikkula and Arnkil, 2006, 2014), Rober (1999, 2005), Shotter (2006, 2010, 2015), Arnkil (in Seikkula and Arnkil, 2006, 2014) and a growing number of other therapists, researchers and academics ensures the waters of family therapy do not stagnate.

The connectionist position proposed by Hoffman unites the systemic, collaborative and communal practices in mental health, education and social care services. This inclusive orientation promotes transdisciplinary creativity (Montouri, 2005). A recent course on dialogical influences in family therapy at the *Metropolitan University* in Copenhagen included participants from teaching, nursing, social work, mental health

services and pedagogues in child care. Whilst the participants came from different backgrounds, the uniting ethos was of applying humanising dialogically informed practices in their professions.

Aspects of dialogicity have offered my practice more pinpoint focus on the particularities of meeting with the other, less in my head and more in my body, so to speak. They have also led to a deeper appreciation of the complex craft of family therapy and its place on the wider political seascape of practice. The heart of the matter is to participate in a dialogue with humility that beats to a political drum. The aim is to 'support the family members agency and strengthen their private networks and psychosocial resources' (Seikkula & Arnkil, 2014, p. 105) and this is inescapably a political, humanising enterprise.

The practical aspects of a dialogical orientation explored here are congruent with therapy as a process of humanisation. This congruence leaves plenty of room for the seriously playful, irreverent, supportive and imaginative in the repertoire of the family therapist. It is a profoundly human endeavour. Recently a 16 year old client told me, as we were reviewing the final session of therapy: 'You can be good at Maths, good at English and computer science. You can be intelligent ... But if you can't connect it's no use ... Therapy should be a sort of professional friendship ... It's not an interrogation.'

If the act of creation (Koestler, 1964) is, 'the uncovering of what has already been there' (p. 120) then the contribution of dialogism to family therapy is to shine a light, like Diogenes' lamp, on the already present. Dialogue is flow and family therapy can continue to be in conversational flow with a broad array of disciplines and approaches to therapy and education. In so doing family therapists may avoid the tendency, especially in times of economic constraint, to close the doors on others with different even contradictory views.

Dialogue, born of humility, broadens our horizons of possibility: 'Horizons are not rigid but mobile; they are in motion because our judgments are constantly put to the test. This happens in every encounter ...' (Gadamer, in Palmer, 2001, p. 48).

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## End Note

- <sup>1</sup> All identifying characteristics including names and locations have been anonymised for reasons of confidentiality.
- <sup>2</sup> I invite readers to make personal points of learning and reflection as the article is read and perhaps reread. These points are likely to be more pertinent for their own learning than anything I prescribe.

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