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THERAPY AS ANTHROPOLOGY

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INTRODUCTION

A person is suffering and seeks help from a therapist. What happens then? Well, that depends on the therapeutic approach and tradition. Does the therapist act like a surgeon and take full responsibility for removing the suffering, does the therapist act as a facilitator and help the sufferer remove it himself, or does the therapist act from a meta position and help reframe the entire suffering situation? It seems that the right choice of action depends on the conception of the job of the therapist and of the whole meaning of therapy. Is it a healing profession? A normalizing profession? A meaning-making profession?

The practice of psychotherapy is traditionally based on *interventions*. An intervention in this tradition is akin to interventions in more technical or mechanical practices – an almost forceful action undertaken by a professional. The interventionist analyzes the problem, plans the necessary action, and predicts the probable outcome before intervening. The professional is the expert in problems and in problem solving, and uses this knowledge to fix and heal.

In this traditional approach, the therapist is the sole expert and, by accepting therapy, the client agrees to subordinate himself to the therapist. The therapeutic position is that of an active agent of change – an educator, a pedagogue, an interpreter, or a subtle

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manipulator. The goal of the therapeutic intervention is leading the client towards a better, healthier human condition, as defined by the therapist. In a sense, therapy is like going to the doctor and accepting her interpretations as authoritative ideas about causation and correct clinical judgment (Montgomery 2005). It is a one-way service.

This is, for the most part, perfectly acceptable to clients seeking therapy, in that they use it for this purpose, and not for others. Help is desired, and help is offered. However, the traditional interventionist approach to psychotherapy carries with it some complications that may be absent in other professional practices of a less relational and less complex nature.

It is a question of *ethics*. Therapy entails a power differential characterized by inequality, and this must be acknowledged in order to avoid abuse (see Epston 2014). A therapist accepting to use this power may use it to manipulate a client in directions the therapist deems preferable. She may for instance give advice on how to live a better life, be a better husband, or about better communication in families. But no matter how sensible these suggestions may seem, they nevertheless come from the experiences and norms of the therapist, not of the client.

Two practical claims come leaps from this premise: One is that therapists are not all-powerful healers. For human problems are embedded in people's own contexts of life, and solutions are to be found by considering those same contexts. The therapist's approach and understanding almost certainly have their roots in different contexts. Hence the therapist could easily *misunderstand and over-simplify*.

This leads to a second claim: Clients do not seek out therapy to become more like their therapists. There lies a very tangible risk inherent in the practice of psychotherapy, namely that of the therapist seeking to transport the client from his state of misery and into a state of mental health or even of normality. A state that the therapist must in some sense represent as a person. The therapist may thus use her power to lead the client towards a specific end goal. This means that the therapist could easily *risk abuse* – in spite of her best intentions.

Therapy becomes a balancing act. Because therapy is a practice of influencing – passivity is not an option. And yet the therapist must beware of misunderstanding, oversimplification, and abuse. Questions arise regarding how best to balance the agendas of the therapist with those of the client; how to make a difference as a therapist while not presuming to know better than the client does. On the one hand taking on the task of being influential, an active co-creator of something new, and on the other hand maintaining a curiosity and appreciation of experiences and norms of the client. It is a paradoxical position of exercising “respectful manipulation” (Mosgaard 2011).

This is not a simple or static position, because it is never a given when to act, and when to hold back; those decisions arise out of constant reflection and participation in each individual conversation. I do not advocate total abstinence from intervention, but an awareness of the reasons behind and implications of *any* intervention. Interventions must be sensitive to this balance.

FOUNDATIONS FOR AN ANTHROPOLOGICAL PSYCHOTHERAPY

This chapter[1] is primarily a reflection on *the professional position*. Even though the idea of an anthropological gaze is introduced, this is not an analysis of the ways therapy is shaped like a rite of passage, nor of the ways in which psychotherapy is a cultural phenomenon in its own right. The focus is on the choices of professionals in therapeutic settings, and the different paths upon which these choices may lead.

I begin by defining the chapter's field of study; firstly the practice of psychotherapy itself, and secondly the theoretical underpinnings of my reflections. I begin by directing my consideration of intervention towards the nature of psychotherapy, which I characterize as a cultural practice and a practice of change and of witnessing. After that, I introduce some social constructionist presumptions relating to this, describing the relational and meaning making nature of being human.

After laying this groundwork, I turn to the bulk of the chapter and look at some of the ways the professional position in anthropology can inspire novel reflections on therapy. Central concepts are participant observation, thin descriptions, and the therapist as a stranger. I conclude on the anthropological inspirations by proposing three paths for the anthropological therapist to take, considering the previous reflections. I name these paths positioning, curiosity, and loitering.

Psychotherapy as a cultural practice

Therapeutic interventions are cultural interventions. This premise is true not only of cross-cultural therapy, but of *all* interventions. As a therapist enters the therapy room with a new client, it is a meeting with a new culture.

[1] The content of this chapter owes a great debt to numerous invaluable conversations with Berit Tankred, a medical doctor with a foot in both camps: Therapeutic practice and anthropology.

Psychotherapy is thus part of cultural psychology (Bruner 1990), in which the search for meaning and interpretation is not understood as an individual endeavor; but ratherstemming from and entrenched within culturally specific discourses. Culture creates and sustains meaning, while being simultaneously created and sustained by systems of meaning itself. We both create and are created by culture, in an active and dynamic process. We are not just passive recipients of events happening to us, making us behave in certain predictable ways; we *act* rather than *behave*. We possess *agency*.

Therapy, in this conceptualization, becomes a conversation between equal persons with equal agency, and not just one person doing something to another person. It becomes concerned with discovering agency where convictions of powerlessness or victimhood have reigned.

What *kind* of cultural practice is psychotherapy? Let me zoom in on what distinguishes this from other practices.

I suggest that therapy is a professional practice existing in a field of tension between the past, the present and the future. It is of course a practice directed at some alternative future, but we can never gain final knowledge of this future; it will always be co-created in the here and now – based on previous experience. In a sense, we human beings are always "ahead of ourselves" (Heidegger 1996, p. 203), which is to say that we always live the present in anticipation of a future. Therapy taps into this condition and becomes a practice of anticipation.

A characterization of psychotherapy must take into account the past and present as well as anticipation of the future. I propose a stripped down, twofold description:

1) Therapy is a practice of change. Changing is at the heart of therapy – therapy is a *talking cure*, a practice of getting better through talking. Through a deconstruction of problems, habits and stigmas, new worlds of possibilities may arise (Parker 1999). Successful therapy requires a transformation.

2) Therapy is a practice of witnessing. This is – in a sense – the other side of the coin, because therapy is not only about talking, but also about having a listener. Some clients do not seek a specific change, but rather they seek affirmation of their experiences and life stories. This is the relational aspect of having an outsider listen to your story of suffering, hopes and dreams (Russel & Carey 2003) – of having a witness to your life.

So if psychotherapy is concerned with changing and witnessing, what can then be said of *therapeutic intervention*? The conceptualization of therapy stated above does not come with a manual. Some may prioritize the changing aspect, and focus quickly upon the expressed goals of the client (i.e. solution focused therapy), whereas others may emphasize the witnessing aspect, and create a non-goal-oriented conversation (i.e. psychoanalysis).

Either way it is a process of two or more people creating and sustaining meaning through dialogue. During this dialogue, some meaning is affirmed, and some is changed. It is a social construction.

Psychotherapy as social construction

“As for me, all I know is that I know nothing”, Socrates allegedly stated. This philosophical stance has deep implications, for how can we ever claim knowledge? On which foundation can we stand to claim a privileged access to true knowledge?

The reflections and arguments of this chapter have their base in social constructionism (Gergen 2009). Many of the concepts derive from this tradition, especially as it has been operationalized in narrative therapy (White, 2007). Social constructionism is a philosophical position drawing on a vast number of influences – from sociology to phenomenology, from literary to feminist theory and from Berger and Luckmann’s (1967) coining of the phrase “social construction” to the philosophical theories of language by the late Wittgenstein (1953).

There are many accounts of what social constructionism is, and to which family of theories it belongs (Gergen 1985), and there are many accounts of what it is not, and where it does not apply (Cromby & Nightingale 1999). For the purpose of this chapter, I focus on two fundamental claims that are to be accepted in the adoption of a social constructionist stance.

1) *Human beings are relational beings*. We live in and of relationships, be it close ones such as families or communities or in a broader sense as members of cultures and larger social systems. With globalization, the advent of the internet, social media and mobile connectivity, communities cannot be defined by *physical* closeness alone, but with what might instead be termed "communication closeness" (Mosgaard 2014). We take part in complex social interactions with close relatives, acquaintances, and distant contacts in a web of relational bonds and bridges.

2) *Human beings are meaning seekers and meaning makers*. We try to make sense of our experiences and observations, and interpret what we encounter instead of just piling up data. As we are fundamentally social beings, the interpretations do not appear "out of the blue," they are constructed socially through dialogue, negotiation, and tradition. Meaning is constructed in day-to-day practice, as well as being borne down through generations via cultural practices. We are swimming in oceans of meaning.

The implications of this are radical. Nothing is real, unless we agree that it is real. This is not an ontological allegation, but an epistemological one, for if human beings are relational meaning makers, we must understand all access to the world "out there", or even "in here" as mediated through the interpretations we make of this world together. We cannot make any claim of privileged access to what is real, good, or true.

This brings professional practice into dispute, since it entails a questioning of professional expertise, for how can we know better than our clients what will be a good life for them? This calls for the professional to strive to show restraint and be tentative in her knowledge claims. Knowledge is power, because whoever controls the cultural discourse controls the

truth (Foucault 1990). The therapist, for instance, has the potential to manipulate because of the power of her perceived or agreed professional authority.

Out of these social constructionist concerns arises the concept of a “not-knowing position,” or a position of “non-expertise” (Anderson 1996). This has often been misinterpreted as a sort of false naivety, or a “playing-dumb” position, in which the therapist pretends not to possess any psychological knowledge. A more interesting way of putting the concept into use is as an ethically sensitive approach – a view of the professional as not being the expert on what is the best life for the client to live.

Not-knowing therapy claims: *The client is the expert* (Anderson & Goolishian 1992). When truth privilege is taken away from therapists, authority can be returned to clients. This is not to say that clients should all stop seeking therapy and start finding their own solutions, by just pulling themselves together or reading self-help books. Social constructionism is not a form of radical libertarianism. Rather it implies a shift from the interesting world of psychological wisdom and psychotherapeutic authority on the good life, to a fascinating world of intentions, life stories, and aspirations of the client. Moving from a culture-centric to a culture sensitive practice.

It is a shift from giving answers – overtly or covertly – to co-creating meaningful futures. It has been called going from being helpful to being useful (Cecchin et al. 1994).

THE ANTHROPOLOGICAL THERAPIST

"*Some years ago, I practiced psychotherapy for 9 years in a small community in northwestern British Columbia that was adjacent to a First Nations (Native American) village. Relations with the people of that village were good, and I would be invited to the village for everything from softball tournaments to major feasts or potlatches where the important social and economic transactions of the community were observed. A portion of my clientele was from the neighbouring village, and I engaged them with my combination of collaborative and constructionist therapies.*

In leaving my former community for academic life, I struck up a friendship with an anthropologist colleague who had worked with people of the village. As things turned out, my anthropologist colleague had also been involved in research on the dream narratives of the villagers, narratives she corroborated with them as being central to their emotional lives.

I knew nothing about these central features of their emotional lives, because I hadn't asked or listened for them.

I later sheepishly consulted someone from that village who informed me that he thought the villagers probably saw such dreams as meaningless or irrelevant to someone like me who practiced western mental health. And I thought I had been collaborative, relevant, and respectful in how I had interacted and listened." (Tom Strong 2015)

We cannot see what is never presented to us; we see what we expect to see, and do not easily see the unexpected. Even the most experienced and collaboratively oriented therapists inevitably have blind spots. Even guided by a not-knowing stance and experience in setting aside therapist agendas, there are always parts of clients' lives that do not enter the therapist's office with them. Often this is not a problem, but it may result in relevant issues being overlooked.

I suggest introducing and applying an "anthropological gaze" to psychotherapy. In a couple of fundamental ways, the professional process of the social constructionist therapist

parallels that of the anthropologist's. The therapist, like the anthropologist, is a "third person" – not privately involved, and yet invited into the most private of rooms. And like the therapist, the anthropologist struggles with the inherent challenges of her own position as a professional within the whole process.

Let me first offer a few words on what characterizes anthropology. Anthropology is the study of human beings in their day-to-day social practices. Its interest is human beings as relational and thus cultural beings. Anthropological inquiry focuses on the logics and ideas inherent in people's interactions, rituals, and everyday activity (e.g. Eriksen 2004).

The field of anthropology has undergone a paradigm shift parallel to the previously mentioned shift from traditional interventionism to a not-knowing approach. From a distinctly expert position to a more humble approach to the people studied. In anthropology this shift is sometimes referred to as *the reflexive turn* (see Foley 2002), and was spurred, amongst others, by Rosaldo (1989), in a text that in content and style challenged ideas about the separation of professional, personal, and private positions. In this approach to anthropology, professionals are urged to figuratively look themselves in the mirror and question the prevailing ideas about objective observation and about the possibility of studying without interfering with the observed culture.

Two major implications are worth mentioning: Firstly, if the professional cannot claim objectivity, this places the observer more closely to the observed. An interest must rise in the anthropologist herself, and a transparency of her deductions and interpretations become a necessity.

Secondly, and because of this, the professional can no longer sustain the traditional role of describing primitive cultures from a privileged civilized perspective. The anthropologist must become concerned with listening more closely so as not to presume to know too soon, what the informants really mean. To the fore is placed a more open, less ideologically constricted way of listening – even when the researcher hears things that do not easily lend themselves to acceptance and understanding; or things that do not fit into accepted truths, models or theories. This is sometimes (see Epston 2001) discussed as an

attempt not to colonize other people with the professional's *generalized* knowledge and be more faithful to people's own *local* knowledge.

The therapist as a stranger

Therapy is not objective observation. Therapists cannot enter clients' lives and a listening position with the illusion of not leaving a dent. Nor is this desirable. Therapists have a task, and a specific position in relation to the clients. They take on this role and enter with the intent of being "decentered, but influential" (White 2000).

This is the position of the *participant observer* (Spradley 1980). It is a position of solidarity with the client's life, his story and ideas about the good life, as well as a position that acknowledges the therapeutic role as being that of a participant, and in this case, an agent of change.

The position of the participant observer illuminates another important aspect of the therapeutic relationship, the paradox of the therapist simultaneously being an unfamiliar person and, in many cases, the most intimate confidant to the client. It seems that this duality of the therapist's position is of great importance to the results of the therapy. Gammeltoft (2010) writes of this double position for the anthropologist. She describes on the one hand how imperative it is to be an outsider, in order to gain access to and sustain the meta position in relation to her informants. She is considered anonymous, a sort of non-person in the lives of the people with whom she is talking. On the other hand, and specifically because of this outsider position, the anthropologist is considered non-biased and is therefore confided in more than would be the case with *insiders*.

Tjørnhøj-Thomsen (2010) writes along the same lines about the surprising intimacy this non-involved position creates. Something new arises, something no one had anticipated – something that neither the anthropologist nor the informant even knew of, prior to their conversation. The professional is therefore not exactly an outsider, and not exactly an insider, but a *stranger*. In the words of Simmel (1950, p. 402) a stranger is unlike the wanderer, who "comes today and goes tomorrow", but a person who "comes today and

stays to morrow", and thus gets to be a part of the client's life for a period of time – and the very temporality of this relationship is what creates the intimacy.

The stranger in this definition is not bound to anyone, is not part of the community and is therefore neither a part of its problems nor jubilations. Consequently, the stranger can be the one to whom people confide. The therapist, like the anthropologist, is thus an intimate stranger – intimate *because of* this position and not in spite of it.

The position of the intimate stranger shows itself often in psychotherapy, as the following example from my therapeutic practice illustrates. A client came to therapy with a feeling that something was wrong with her. She had suffered an accident some years previously, which resulted in a brain injury. This meant that she became tired more easily, and had to reduce the amount of hours she worked. She was able to keep her academic position, where her employers had shown understanding for her situation, preferring to offer her special terms rather than to lose her altogether. Consequences of this included a change in her career plans and reduced earnings, precipitating a decline in living standards. She experienced a lot of sadness and a sense of resignation.

The conversations turned out to become more of an identity reconstruction process, rather than a goal oriented one. At the final session, she had not had any change in her physical abilities, her job or her career outlook; but she had moved to a different place concerning questions of who she saw herself as, and what future she imagined for herself. She came in the door at the beginning of the process expecting some tools for making her life more manageable, and ended up feeling better by accepting her life's limitations and finding new possibilities within these frames. She hoped for a change, but became satisfied with that specific change not being possible.

She knew none of this at the beginning of the process, and – just as importantly in this context – neither did I as the therapist. It was the result of a mutual curiosity regarding her situation. As she stated, it came from a trusting therapeutic environment that led her to dwell on subjects that she had not dared talk to others about, and that she had not even dared to think about herself.

Culture, discourse, and interpretation

It is definitely possible to take culture too seriously. Debate in the media, and, at times, political discourse show an alarming tendency of doing just that. Opinions are voiced about the nature of "their" culture or our own, with no apparent aim to bridge eventual differences, or create better understanding, but rather as a polarizing attempt to define ourselves through negative images of "the other". This sometimes takes the form of the social psychological phenomenon of ingroup and outgroup behavior (Brewers 1999).

I propose a more complex and flexible concept of culture. Culture is a broad and overarching concept, and it would be a mistake to make uniform claims about the meeting of cultures in therapy situations. Cultures do not predict a certain set of social constructions, instead any culture can be understood as a complex web of possible meanings and permitted practices, and the boundaries around these meanings and practices are more fluid than solid. A person can be considered part of a culture, even if a number of that person's ideas and actions do not normally comply with the cultural rules.

A useful concept for grasping more of this cultural complexity is *discourse*. Discourses are the ways we talk about and understand our world, the ideas available to us at a given time, during given circumstances (Davies & Harré 1990). Any culture has multiple discourses, often in competition with each other, and often ordered in hierarchies, so that some are more dominant than others. Therapists can have multiple ideas about the good life and healthy relationships, and they will meet with the client's multiple ideas, which are often very different in their essence. In this sense, therapy is a meeting of discourses, and can even evolve into a *battle* of discourses. The worst case scenario is the subjugation of the client's discourse under the therapist's, but a more common outcome seems to be a total lack of meaningful progress, because the therapist and client talk past each other.

An illustration of this point: A family of Arabic origin consisting of two parents and their two teenage children enters my Danish therapy room. The cultural differences immediately spring to attention, differences in values and attitudes; but also differences in the social construction of meaning on a more fundamental level, such as ideas of love and commitment. I spend a lot of time getting to know these – for me – alternative conceptions

of love and relationships, so as not to let my own agendas or preconceived discourses take over. Over the course of some sessions, and even though I feel the connection is good and that my respectful approach is working, the family still expresses concerns that the therapeutic conversations are not actually helping them.

During a shared reflection, it becomes apparent that I, in my eagerness to be appreciative, have overemphasized the differences between my own culture and my clients', and underestimated the differences between the family members themselves. Regardless of the fact that they were all part of the same cultural traditions, there were immense differences between the understandings of the parents and those held by their teenage children. As this realization was broached in the subsequent conversations, it revealed that not only cross-generational differences, but also huge ones between the two parents were causing considerable conflict, an issue that had previously been overlooked. It seemed that even cultural sensitivity could overshadow sensitivity to differences in discourse.

FROM THIN TO THICK DESCRIPTIONS: THREE PATHS

Psychotherapy carries with it some perils: One is the peril of *knowing better*, and in the process taking the therapist's knowledge as truths and not hearing the knowledge of the client. Another is the peril of *knowing too soon*, and in the process not dwelling on the words and stories of the client, thus ending up *knowing enough*.

Knowing better and knowing enough bring the risk of hasty conclusions. *Now we know what the problem is, and what needs to be done*. Conclusions are what narrative therapy theory, with a phrase borrowed from the anthropologist Geertz (1973), calls "thin descriptions", since they exclude alternatives, doubts, and nuances.

The "participant" part of the therapist as participant observer therefore seems to lie in taking a stand against thin descriptions that may in turn lead to narrow *identity* conclusions (White 2001). Descriptions without a certain thickness do not contain much information, and they do not spur further interest or imagination. They are just descriptions, and may lead to labeling – even stigmatization – because they close more doors than they open.

Every description highlights certain aspects and downplays others. An example from Lakoff & Johnson (1980, p. 163) makes this point clear:

"I've invited a sexy blonde to our dinner party.

I've invited a renowned cellist to our dinner party.

I've invited a Marxist to our dinner party.

I've invited a lesbian to our dinner party."

The same person may fit all these descriptions, but each description makes us see different images in our minds and thereby expect different experiences, even different persons at the dinner party. The point is that this will influence not only our expectations, but also our concrete experience when meeting the person, and may very well guide our preoccupations and questions.

Therapy is, in the words of Hoffman (1990), an art of lenses, and what is seen depends on the lenses of the therapist. She may interpret something as innocent as a smile as

anything from happiness to hostility, or even a symptom of mental illness (Scheflen 1978). The therapist-client relationship in itself may lead to certain ideas and interests that will guide the therapeutic interview. The therapist may for instance focus her attention on the client's suffering, which in turn may lead to emphasis falling on the problematic stories and downplaying the successful or unproblematic stories. This of course follows the renowned interventionist tradition in psychotherapy that I discusses earlier – a tradition of "getting to the bottom of" problems with the purpose of making the correct and most efficient intervention. But this approach may hook the conversation onto thin problem focused descriptions rather than thicker, more complex ones (see Mosgaard & Sesma-Vazquez 2017).

Sometimes interpretation is guided by knowledge of the client before therapy even begins. A therapist may have read some case files, she may have talked with a case manager on the phone, or she may have formed an impression based on the first appearance of the client standing in the doorway. These interpretations highlight the influence on therapy from unspoken cultural discourses of treatment authority and of psychological wisdom.

Interpretations may even vary from day to day. One day the therapist has read a book on narrative therapy, and is therefore guided in her therapeutic interests to ask externalizing questions; another day she may have just read an article about cultural psychology and brings an anthropological gaze to the conversation (see Sluzki 1992). The therapist may have just seen a movie or had a deep conversation with a close friend, and all this may color the interpretative lenses and lead to some dialogical spaces opening up and not others.

How do therapists handle issues of cultural, discursive, and interpretative complexity? Which skills or stances may be helpful in discovering thick descriptions? I suggest three practical paths for the anthropological therapist: Positioning, curiosity, and loitering.

1) Positioning

No man is an island. We are all connected, and this in itself complicates as well as enriches our lives. It also helps us escape ideas of singularity – in relation to perspectives, interpretations, discourses, and of cultural truths. One of the skills involved in challenging thin descriptions is that of taking the perspective of other people, the act of stepping into someone else's shoes and seeing the world from that position. Fluidly moving between agendas, concerns, constructions, and perspectives (see Rober et al. 2008). The changing of positions in itself challenges truth claims, because talking about other people's social constructions makes it impossible to maintain the notion that there can only be one truth.

The anthropologist takes positioning into account when facing strange cultures and meeting these as being natural to the people living within them. We take the other people's perspectives seriously when we realize that they are meaningful perceptions and meaningful ways of living. Even though they are different from ours, they are, nonetheless, the social constructions at which they have arrived. This does not mean that their views and truths are less advanced, or a more primitive version of ours. As already stated, we cannot claim privileged access to the 'real' truth.

Positioning is a fundamental part of systemic therapeutic practice, evident in, for example, the use of one-way mirrors or of circular and reflexive questioning (Tomm 1987). Here the questions widen the lenses by not being about a client's own thoughts and feelings, but about the client's perception of other people's thoughts and feelings, and ultimately about relationships instead of individuals. Positioning is beneficial not only in moving away from one-sided stories and towards thick descriptions; it also aids in the perception of stories as taking place within relational contexts, with interpretations and discourses taking form and changing in the course of relational processes.

As an obvious example of the advantages of positioning, couples therapy springs immediately to mind. Couples often start out with very clear ideas about what needs to change in order to make everything better. Often it has to do with the other person changing his or her ways of talking or behaving, and usually the participant's ideas appear mutually exclusive. Positioning questions assist both client and therapist in seeing through

the other person's eyes. It makes it impossible to hold on to a view of only one way of seeing things. This helps raise other questions: How does he or she perceive events? What approach to constructing the situation is being followed? What do I learn about the other person that I did not know of before?

2) Curiosity

"I don't want to be curious", a woman in family therapy once proclaimed, after a conversation about her adult daughter and her husband and children. This initially came as a surprise to me, since I as their family therapist considered curiosity to be a sign of interest. However, as I was to learn from this woman, curiosity can also imply a nosiness that may actually be a sign of too much interest. With this in mind, I will nevertheless advocate the use of curiosity, not as sticking therapeutic noses in where they do not belong, but with the purpose of guiding towards new and relevant perspectives.

While positioning helps therapists take a relational approach to the truths they – and others – carry around, it may also become a mere academic exercise in jumping from one perspective to the next. Positioning, therefore, calls for a genuine interest in the perspectives of the clients, a passion for new perspectives, and a constant awareness that hypotheses are never the end goals. An openness to the not yet known and a tolerance of uncertainty (Seikkula & Olson 2003).

This openness I call *curiosity*. It is curiosity in the spirit of Cecchin (1987) and related to the Milan group's definition of neutrality, in the sense of not allying oneself with any one client, but also not allying oneself with any single construction of reality. This involves the therapist always being on her toes so as not to "marry" her own hypotheses – or the client's, for that matter.

On the one hand, curiosity is a position of always showing interest in the truths and ideas that are yet unknown. This aids an appreciation of the client's ideas, cultural codes and practices without passing judgment. For no matter how much suffering they may create,

these are social constructions and relational patterns with inherent reasons, logics, and histories behind them (see Selvini Palazzoli et al. 1980).

On the other hand, this appreciative approach demands a critical stance towards the client's truths, as well as the therapist's – especially when they cease to be local truths, and claim to be general truths. This is a position of irreverence (Cecchin et al. 1992). If truths are always located in a cultural and discursive context, then therapists must be wary of *any* generalizations. If they hear a client, or themselves, say sentences such as "That is just the way it is", "She is a typical borderline", or any other universal truth claim, they can look at this with deconstructive fascination. How did that truth get there? What meaning has it helped create? When is it helpful? And when is it not?

Again, couples therapy provides a case in point. Applying positioning questions may lead to a climate of debate or argument if not combined with a sense of curiosity. The husband or wife, or even the therapist, may listen to the various perspectives with their ears attuned to flaws in logic or for weaknesses, because of an agenda of reaffirming one's own preconceptions. Curiosity is a way of insisting upon not only hearing, but also actual listening; and not only listening, but witnessing. This may lead to questions for the participants to ask themselves: What is this person trying to say and do in telling the story this way instead of another? What intentions does this reveal? What does this tell me about the person sitting next to me?

3) Loitering

Psychotherapy is all about movement. The conversation does not stand still, but is in many important ways concerned with "how to go on" (Shotter 2010). I previously described psychotherapy as a practice of change, a change that implies the therapeutic narrative of getting from somewhere unwanted to attaining a more desired future. Often therapists have a vague image of this future in their heads, and therapy is then concerned with matching this with the client's own image, and through the therapeutic process arriving at some preferred point (Mattingly 1998).

However, as described earlier on, therapy is not just a practice of changing unwanted situations; it is also a practice of witnessing. It is not only about transforming and battling problems, but in many respects about affirming the problems' perceived reality and the stories of suffering.

In the words of Derrida (1996), before the "no" comes the "yes". A deconstruction of problems or problem stories is not just a critical process. It also involves taking this problem story seriously. In Derrida's description of deconstruction, he posits that in order to deconstruct, we must accept. Before any criticism comes assent. In a broader sense, in order to create meaningful change in the future, we must show an interest in the situation presented in the here and now.

In this process, the anthropological psychotherapist is in no hurry to understand correctly, to know, to diagnose, or to create a change. The therapeutic process becomes instead, with a metaphor from narrative therapy (Carey et al. 2014), a process of *loitering*.

Loitering means a kind of "hanging out with", or dwelling on certain aspects of the client's story – some externalized aspect of this story or some other issue that seems worthwhile. This is contrary to the perceived or real demands of a fast and efficient approach to therapy, in which goals are to be identified and swiftly pursued. Loitering in therapy is a challenge to the idea that a fast method leads to faster recovery or faster problem solving. Sometimes the fastest way to get there is by going slowly.

The "hanging out" process is not merely strategic, it is a natural consequence of moving from knowing better and knowing enough to not-knowing. It is akin to Schein's (2013) concept of "humble inquiry", a way of asking questions that requires time, reflection, curiosity, and making yourself vulnerable. Vulnerable, because neither the therapist nor the client knows where the process is leading, and hereby the therapist exposes herself; she does not know the answers to her questions, or have a preconceived intervention to fall back on.

This allows the therapist not only to facilitate transformations, but also to be transformed herself (Katz & Alegría 2009). From preconceptions to changed conceptions, from one set

of prejudices to another, albeit widened, set of prejudices. This is an anthropological process of intimate strangers co-creating the not yet known and not yet existing realities and going from being helpful to being useful. From knowing better, to entering a realm in which the therapist can truly be surprised.

The traditional expert interventionist tends – metaphorically – to walk one step ahead of the client, while the non-expert position runs the risk of leading to the laissez faire practice of walking one step behind the client. The loitering stance makes the case for “walking alongside” the client (Ness et al. 2014). In this way, the humble inquiry does not come out of nowhere, but is a genuine process of co-creation. It can be based on hypotheses, but also based on a positioning and a curiosity necessary to reject any hypotheses that do not prove convincing. Even more radically, the anthropological therapist may change the nature of her whole quest, if some new information jumps forward and captures the attention of both therapist and client. Openness and complexity guides the way.

To illustrate this, I present an example of a therapeutic encounter, again from my private practice as a psychologist. The client consulting me told a story of abuse in her childhood, with the sessions consisting of me asking questions, in an attempt to help create a life in the here and now - free from the traumas of the past. Questions of positioning helped reflect on the events from different perspectives, and questions of curiosity focused the process on stories of recovery and of agency.

However, every session seemed to start from scratch. At the beginning of every session, the client presented a new childhood story of abuse and suffering. Even if the session ended on a positive note, the next one consistently started on a low note. I began to worry about whether my approach was wrong, turned the positioning questions to myself as a professional, and asked the client for feedback. How did this conversational process make sense to her?

The client then expressed her satisfaction with the constructive nature of the conversations, but also expressed gratitude for being allowed to dwell on the traumatic stories. It was important to her, she said, to keep reminding herself of the atrocities,

because they also reminded her of other important lessons. She appreciated the opportunity, provided by the confidential relationship, of being affirmed in her understanding of these experiences as being wrong. The act of telling made her feel less alone with her stories.

From this point on, I allowed myself to dwell even more on talk of this trauma, and abstained from a need to “look at the positive”. It became an important process for the client of recognizing significant values, and having a witness. A process without haste, and yet a process steadily moving towards a preferred future for the client.

CONCLUDING REFLECTIONS

"Anthropology [requires] the open-mindedness with which one must look and listen, record in astonishment and wonder, that which one would not have been able to guess."
(Margaret Mead 1950, p. xxvi)

How can psychotherapy ingest some of the astonishment and wonder of anthropology, and still be called psychotherapy? I suggest that the practices of psychotherapy and anthropology could benefit from absorbing some wisdom from each other. From the therapeutic practices comes the realization that a professional always brings hypotheses and agendas to the meeting with a client. Therapists are there to make a difference, to help move from thin to thick descriptions, and to figure out how to go on.

From anthropology comes the reverse realization: An openness to what may not fit the clinical preconceptions, but also an approach free from interventionist agendas, driven instead by a wish to expand the stories of the participants and the ideas of the professional.

The anthropological therapeutic position takes the paradoxes of the professional practice seriously, perceiving them as conditions, rather than problems. The most prominent is the duality of, on the one hand trying to listen to and speak the client's language, and on the other hand avoiding "going native". The therapist works in a field of constant fluctuation between distance and closeness, between anticipation and surprise, and of trying to be useful in bringing about change, while not colonizing the client with professional truths – listening to local truths and being wary of general truths. Curiosity and irreverence go hand in hand in a process of continual ethical consideration.

A person is suffering and seeks help from a therapist, an intimate stranger. Both embark on a journey into unknown territories, humbly loitering around stories of identity and co-creating possible futures, futures that may surprise both client and therapist.

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