# Normalizing Ourselves for the Other: Inviting Humanitarian Conversations Beyond Formulaic Relationships. Part II[1]

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## Collaborative-Dialogic Methodologies Practiced at the Now I See A Person Institute

Humanizing Therapy: A Gentle Collective and Linguistic Participation.

Now I See A Person Institute (NISAPI) is a nonprofit training and research organization dedicated to Collaborative Dialogical Practices in addressing mental health and substance-related challenges. Modeled after our foundational work at the Houston-Galveston Institute, we continue to advance the principles of social constructionism and postmodern philosophy-particularly the concept of *dis-diseasing* mental health. As described by Swim et al. (2024), our perspective and methodology emphasize relational and linguistic perspectives over diagnostic labels, which often highlight deficits. We partner with clients to uncover inherent strengths and self-agency, transforming narratives of suffering into stories of empowerment and recovery.

> Some therapists we encountered seemed to follow rigid protocols, drawing from textbooks rather than real-world heart and common-sense wisdom. Others brought their own unresolved emotional baggage into the room, limiting their ability to truly see us. It's hard for clients to recognize when therapy is actively harming us because we are often taught to trust the *"expert"*, almost unconditionally, as part of the process. (A story in their own words-transcript of a mother, 2024).

Our sessions are often lengthy and inclusive, involving whomever is most supportive of the individual experiencing distress. Given the intensity of the

[1] Due to the length of this paper, it is presented in two parts. The reference list is at the end of Part Two.

process, sessions may last over an hour and may even occur daily to ensure the client's safety and well-being. When time is limited, conversations often shift into assumptions—where the clinician fills in content and context rather than co-creating meaning with the client (Swim, 2022). Recently, we've seen a resurgence in the systemic field of concepts such as transference, countertransference, and the imposition of boundaries on clients. These frameworks risk returning to an internalized view of problems-locating issues *within* individuals-an approach our field once sought to move beyond. Such internalization can lead to unfortunate outcomes and disempowered relationships.

> *"I became liberated when I told myself I am a person who experienced trauma, but I am not the trauma. If my trauma had been seen and not suppressed by others' versions of me, perhaps these years of not trusting myself would have lessened"* (Swim, 2023).

We believe in our clients and in their capacity for growth. We do not see them as broken or defined as patterns. Instead, we honor their narratives and experiences. Clients-whether they are the ones in visible distress or significant family members-are viewed as credible and central to the process. Each participant is welcomed as an essential author of their own individual and relational meanings. Shared understanding, whether in struggle or success, is vital. Every person brings unique perspectives and strengths to change. Through collaborative efforts, even the most controversial or marginalized family members can become cohesive partners in creating long-lasting, sustainable transformation (Swim, 2021; Swim, 2022). Everyone deserves an active and respected voice.

## Innovative Approaches Fostering Genuine Human Connection

> For those of you in the field, I ask: Are you truly listening? I hope you allow space for your clients' wisdom to reveal itself and don't get stuck behind quick judgements and theories, standardized tests. Don't silence their deep human experience with your protocols and assumptions. Your clients deserve more than expertise-they deserve your humanity (A story in their own words-transcript of a parent, 2024).

As clinicians, recovery consultants, and coaches, we entered this field to walk alongside people as they navigate life's most difficult moments. At one point in time, the field of systemic and marriage and family therapy offered this groundbreaking perspective: that the reasons for emotional and psychological distress were not internal flaws, but instead deeply rooted in a person's contexts and relationships. It was a time where -therapists listened to stories of survival and perseverance. Their courage to persist, to seek meaning and connection in the midst of pain, revealed a kind of heroism that defied diagnostic categories.

When we view people through the lens of their lived experiences, rather than through pathology, they are no longer *voiceless*. This theme-of a deep longing to be heard-has echoed in all our work and research. When people are genuinely heard, new possibilities begin to emerge. Transformation becomes possible not through education, control, or correction, but through recognition and relational presence (Swim, 2001). Even in well-meaning attempts to diagnose or educate, there is often an inherent message that something is wrong with the person, rather than that something has happened to them. In doing so, we miss the wisdom people carry; we overlook their basic, inherent strengths for self-directed solutions. Worse, we risk leaving them dependent, confused, and stripped of the certainty and clarity they once held. However, when we move away from a disease-centered lens and truly honor their narratives, we invite healing through connection, dignity, and shared understanding.

As practitioners committed to Collaborative Dialogical Practices, we believe healing emerges through relationship, not prescription. We invite clients to become active participants in the conversation, co-constructing meaning and possibilities alongside us. This approach restores agency to individuals and families, reminding them that they are not defined by a diagnosis or fixed identity but are evolving, resilient human beings. The clinician's role shifts from expert to companion-one who bears witness to the client's story with curiosity, humility, and respect. In these shared spaces, recovery is not something delivered; it is something discovered-together.

## The Philosophy and Methodology Behind Humanizing Therapy

As previously discussed, we continue the work of our predecessors by embracing the concept of *dis-diseasing* mental health. Our approach centers on fostering relational and linguistic perspectives, rather than adhering to diagnostic labels that often highlight deficits. At the Institute, we collaborate with clients to uncover their inherent strengths and sense of agency-transforming stories of suffering into narratives of empowerment and recovery.

The name *Now I See A Person Institute* (NISAPI) was coined by a student. She explained that, for the first time in ten sessions, she left her progress notes outside the door-along with what her team members had said about the client, previous records, and treatment plans-and walked in with an open heart and mind. For the first time, she truly saw a person. She kept repeating, *"Now I See A Person."*

Prior to that moment, she admitted to feeling angry with her client-frustrated because the client wasn't listening, wasn't changing, and wasn't following a treatment plan she had created without the client. She wanted the client to

cooperate with her own agenda, not one that was co-constructed. The intensity of the situation scared her. We engaged in a conversation about what it means when someone says they *"hate a client."* It is not the client we are truly angry with (Swim & Kinman, 2018).

This prejudice may arise because the client is not responding as expected, because you dislike who you assume they are, or because you are viewing them through socio-cultural, or political lenses. These cultural and ethical considerations extend beyond societal influences-they include the personal ethics each individual brings into the therapeutic conversation (Swim, 2003). Recognizing these biases is essential to fostering genuinely collaborative and respectful therapeutic relationships.

## The Methodology Behind Humanizing Therapy

The practice of *"Humanizing Therapy"* centers on:

- Encouraging humanitarian conversations that transcend formulaic relationships.
- Addressing human suffering without amplifying trauma through diagnostic labels.
- Fostering a focus on strengths and the natural coping mechanisms of individuals.

This approach emphasizes creating safe, judgment-free spaces where clients and therapists co-develop pathways toward healing and purpose. It includes those important to the client, which may involve legally mandated participants, specific family members, or others who can offer meaningful support (Anderson & Goolishian, 1992; Swim et al., 2012). By centering the client's voice and relationships, the process fosters agency, connection, and a sense of belonging critical to sustained recovery.

Our clients heal and *shed severe mental illness labels*. Being seen as a person rather than a label reflects normalcy, and individuals grow to see themselves as people who have experienced trauma, symptoms, suffering, and ultimately, healing (Swim, 2021). Milutin Kostic, Rod Nardi, Prateeksha Sharma, and many other colleagues have written about how severe symptoms and suffering can serve as coping mechanisms (Swim et al., 2024; Myers, Priest, Mikawa, Zilifyan & Swim, 2012).

As previously stated, and to emphasize, when individuals see themselves beyond a mental illness label, they thrive. Suicidal thoughts and psychosis subside, families

reconnect, and they create the lives they desire-opportunities once hindered by suffering. Our case studies show how the focus on medicalization often restricted their ability to solve problems independently.

## Rebuilding Trust and Fostering Normalcy

Our work addresses challenging issues while collaboratively rebuilding trust and fostering normalcy. We create relational spaces that prioritize wellness and healing, allowing clients to explore their narratives free from traditional therapeutic constraints. Our research emphasizes the importance of environments where freedom and dialogue thrive, ultimately empowering individuals to reclaim their stories.

The majority of our clients are referred because prior mental health services were unsuccessful. Many clients were previously hospitalized several times and were informed they had a severe mental illness diagnosis. They could not understand how one day they were able to function, and the next were told they would never recover, that they would never work or go back to school to finish their studies. Their stories reflect the moment when hope was lost, when they began to doubt themselves, when they became fearful of everyday functioning, and when being 'normal' became a past memory.

## Rethink Possibilities-Inviting and Honoring Multiple Voices and Agendas

Although we always tried to incorporate a setting of normalcy rather than something clinical, from 2007 to 2020 we expanded our approach by integrating horses and natural spaces-meeting with people in their homes, in parks, or even in their own gardens. When we gathered at horse ranches or outdoor spaces, we fostered collaborative relationships around shared experiences such as picnics, sitting by lakes, watching birds, playing soccer, creating art, planting together, racing with adult staff, and interacting with horses. Often, the so-called *“problems dissolved”*-not through planning or intervention, not through psychological themes or a language of deficiency-but in settings where dignity was preserved and positive narratives were allowed to flourish (Anderson, 1997; Anderson & Swim, 1993; Swim, 2022a; Swim, 2022b).

Those who initially joined these sessions often carried heavy burdens, speaking of trauma, loss, and difficult relationships with parents, teachers, social workers, lawyers, and probation officers. In these natural and collaborative environments,

clients, lawyers and mandated social workers engaged in real-time reflective conversations. They explored multiple voices (polyvocality), developed mutual understanding, and began forming new partnerships rooted in respect. Over time, these support team members began to see clients as whole people-not just as cases or problems-allowing for the co-creation and implementation of meaningful, personalized actions.

This shift invited what we call *freedom*: a rethinking of norms and an opening to new forms of understanding. As described by Swim (2020), different people in different roles, at different times, live in what they experience as distinct realities. Thus, as Shotter (2008) notes, we must begin to rethink what we mean by 'reality'-to see it as differentiated and heterogeneous, dynamic and ever-changing, made up of countless interwoven moments and events, each with its own meaning (Shotter, 2008, p. 14).

In all of this, we remain committed to inviting respectful, genuine, and humble conversations for all involved (Andersen, 1997; Anderson & Swim, 1994; Anderson, 2013). We ask to be invited into relationships centered on wellness, not pathology. We take great care not to shame anyone with our presence or our questions. Rather, we seek to add to what is already occurring-and through that addition, to co-create new possibilities. We never know in advance how transformation will unfold, but we do know that if we humanize ourselves for the Other, we create a path forward.

This humanizing path moves us away from formulaic thinking about how or why events, symptoms, or experiences occur. Instead, we invite novel and collective acts of rethinking, reflecting, and understanding-acts that are meaningful and necessary to the people in the conversation. These conversations are alive; they require flexibility, responsiveness, and permission to evolve from person to person, moment to moment, and context to context. In doing so, we create conditions in which words of suffering may dissolve-and new, life-affirming narratives can emerge.

## Exploring Ethics in Therapy

In the 1990s, Swim began exploring and researching ethics in therapy. *"I was working on an article about a heroic teen who was dying from not eating. Her father claimed she had a condition he referred to as 'white girls' disease.' This teen, a person of color attending a private school, had chosen to die by refusing to eat. She had been hospitalized continuously for two years prior to our meeting. Through the efforts of*

*my team—one intern and one trainee—this young woman chose life. She was never hospitalized or medicated again. Her story is documented in"* (Swim et al., 1998).

We followed her for ten years. In her testimony, she spoke about how previous services did not inspire hope and how she tried to protect her family members from blame. She explained that due to prior services, she had lost her position on her school team, and her life became filled with endless appointments and isolation due to consistent hospitalizations. She said her will not to live was sparked when the coach benched her. This was her narrative, and we respected it. We didn't ask why or place blame on the parents or her. We were saddened by how all involved were affected.

She credited our team for supporting her transformation, emphasizing the importance of having a safe space during difficult times-a space where she could speak freely and simply be a teenager, rather than feeling labeled as *"Hester Prynne from The Scarlet Letter."* She did not wish to be identified by a diagnosis such as anorexia, but rather to be seen and known as Bettye. We were privileged to witness her *"rebirth"* and transformation (Swim et al., 1998). Over the years, we remained in contact and were honored to follow her journey into a successful professional life and the creation of her own family. This happens with the majority of those we see who have had unsuccessful treatment histories. They wish to stay in touch and celebrate their reclaimed lives. We may not hear from them for ten years, but we are the people they remember from the time they found freedom.

Her story is not isolated. Our research has shown that when clients are experts in their own lives and feel valued and believed, the possibilities for change unfold. We, as therapists and clients, create ethical partnerships that are tailored to the individual and reflect the immediate thoughts and needs within the partnership of ethical actions (Swim et al., 2023).

Because we witnessed clients continuously transforming from severe trauma and symptoms-despite years of unsuccessful treatment-we decided to research what constitutes the *"right and good"* in therapy, or Process Ethics. Our clients shape the direction of ethics in therapy. Through meeting with this family, we learned about the teen's severe condition and the parents' heartfelt concerns and confusion as to why she was not improving. The therapeutic team's approach to her treatment reflected a deep consideration of both the cultural and systemic factors involved. In the past, different family members had been blamed. The mother was the primary breadwinner, and the father was a stay-at-home parent. Additional children had been adopted when family members were unable to care for them. One parent was a part-time head of a congregation. One can see how these words

of content created many hypotheses about how and why this happened. Assumptions are so easy to occur in any helping effort.

The client did not wish to search for the why, but rather how to live. Little by little, with conversations she described as *"non-therapeutic,"* she started to eat. After she began eating, the question arose: Did the therapists cause her to eat? From a constructionist perspective, the focus is not on determining what exactly happened, but rather on the meaning-making process that unfolded. What was observed was a teenager engaging with a therapist in a supportive, enjoyable environment—listening to CDs and exploring possible futures. Gradually, the client came to the decision that life was worth living.

## Process Ethics: A Foundation for Healing

What happens when people seeking support are viewed as normal human beings who are going through difficult times (Nepustil & Swim, 2022)? When we honestly care about others and genuinely invest the time to attempt to understand the hardships they face? When we embrace the idea that people can get over *"mental illness"* and invite others within a person's community to join in the acknowledgment of a person's strengths and capacity to heal? We invite transformation (Swim, 2021). We enter into the process of finding and embracing ethics in each conversation.

In *Process Ethics: A Collaborative Partnership* (Swim et al., 2001), Process Ethics reflects the belief that clients with severe symptoms can transform and heal within reflexive conversational spaces. The main premise of Process Ethics centers on clients determining what is *'right and good'* for each person in therapy, and, along with their practitioner, mutually exploring how this can be obtained. These principles are individually tailored and collectively created through dialogue in the therapeutic discourse and relationship. Process Ethics cannot be replicated but must be integral to each therapeutic conversation (Anderson & Swim, 1993; Swim et al., 2001).

> Characteristic of the client-therapists relationship are individualized and embody a process of hearing, listening and talking, of meaning being informed and formed (Anderson, 2001).

Within Process Ethics, relational connection, full presence, and sacred conversations enable clients' innate strengths to transcend extreme pain and symptoms. It is the role of the therapist not to interfere with these processes, even with good intentions. Accidentally, we can contribute to the creation of new problematic narratives that were not previously evident. We believe that all therapeutic conversations should be held in honor, as people's words are sacred. We often hold information that has never been spoken aloud before (Swim, 2003).

Process Ethics involves an egalitarian partnership rather than a set of predetermined standards. It is our responsibility not to worsen the original problem narrative by adding deficiency language. In our efforts to help those who suffer, we need to examine our actions and words to avoid inadvertently preventing healing (Swim et al., 2001). How can we prevent our ideas or theories from being imposed on someone? How can we avoid interfering with natural healing?

## Relational Connectedness: A Partnership

Relational connectedness refers to the degree to which clients and therapists engage with one another and how they organize and coordinate their interactions (McNamee & Gergen, 1999). Relational connectedness reflects the propensity to embrace and understand the personal narratives of clients experiencing life burdens. Ethical conduct evolves, enabling the therapist to engage in dialogue that provides an opportunity for the social, relational action of listening and talking. The voice of the client is heard without the therapist needing to interpret what clients say from their value system, experiences, or formalized research findings and paradigms of practice (Andersen, 1995; Andersen, 2001; Anderson, 2013; Swim et al., 2001). Within relational connectedness, discourse defines social communicative ethical action. A relational process unfolds to serve the creation of negotiated meaning that produces a self-tailored partnership (Anderson, 1997; Anderson, Carleton, & Swim, 1999; Anderson & Goolishian, 1992; Anderson & Swim, 1993). Clients see themselves as the guides of their services and are in charge of the treatment and the direction of therapy.

## Being Fully Present to Listen

- Full presence refers to a therapist's posture of genuinely honoring and valuing the client's and community's narratives by speaking honestly and caringly, as well as co-creating genuine trust and humility. This enables the strengths of the client to abound and new possibilities for change to arise.
- Achieving full presence requires clearing one's mind of certainty and exploring what the client is saying. This involves hearing without assumptions.
- Collaborative practice recognizes the power of language. The words we use as professionals can co-generate new possibilities and highlight unique gifts. Language can foster hope and drive sustainable change, helping people embrace meanings that shift and dissolve problems as they gain momentum in their lives.

- Considering *"symptoms"* or *"problem behavior"* as words that describe a person can be harmful. How can we create meaning in difficult situations that offer opportunities to connect with people from a place of humility and grace? It is easy to use deficiency language to represent normal actions and reactions. As learners, we adopt new languages to describe human suffering. By decreasing deficiency language, one invites being fully present. Being fully present to listen leaves behind what is important to us but not to the clients. Hearing without prejudice or right and wrong thinking, and seeing without deficiency labels helps us to be fully present (Swim et al., 2023).

## Sacred Conversations

- We believe that the therapist is in a sacred conversational place when engaged in therapeutic conversation (Andersen, 1993; Andersen, 2001; Anderson, 2001; Swim et al., 2001).
- If we approach conversations with clients as inviolate exchanges, we can invite relational connectedness and enact full presence.
- We appreciate the uniqueness, weight, meanings, and complexities of the clients' situations. We recognize the privilege of understanding and sharing in the depth and breadth of another's life. Our focus is on fostering a continuity of dialogue, rather than reconstructing perspectives that can lead to more pain and/or harm because they deviate from what was originally brought into the therapeutic discourse (Andersen, 1992; 1993; 1995; 2001).

Sacred conversations represent what happens when a client feels comfortable to speak. There is no fear of shame or judgment. The conversation is fluid and alive. The client informs and speaks aloud, often for the first time, themes that are important and themes they wish to change. Within these new conversations, re-authoring and musings about desired change occur. Clients achieve cessation of symptoms, the end of mental illness as an identity, and perhaps, for the first time, find freedom.

## Our Ongoing Studies

The voices of those we serve transcend borders, impacting diverse communities around the world. Our work illustrates the profound transformations that occur when clients are engaged in ways that honor their local voices, lived experiences, and systemic memberships. This article advocates for the continued exploration of

non-linear, client-aligned, and member-inclusive therapeutic practices that promote relational wellness and sustainable recovery.

Clients represent diverse backgrounds, encompassing variations in race, culture, socioeconomic status, age, and traumatic experiences. This diversity deepens understanding and highlights the importance of personalized therapeutic approaches. Participants emphasize the value of dignity, active listening, and the absence of assumptions. They express appreciation for being seen as unique individuals, rather than having their experiences compared to others-an approach that fosters renewed hope and self-determination.

Training, research, and supervision are conducted in collaboration with colleagues across multiple countries. On a quarterly basis, international partners convene as part of a shared *"call to action"* to engage in mutual learning, research, and clinical exploration alongside former consumers and recovery consultants. This ongoing collaboration is committed to cultivating communities centered on meaningful, relational, and context-sensitive mental health practices.

## Conclusion

The following transcript from a case study offers a powerful example of how agency, connection, and meaning-making can foster recovery when individuals are seen as capable rather than pathologized. As a valued contribution to this document and a fitting conclusion to the article, it underscores the significance of Collaborative-Dialogic methodologies in couple and family therapy. The transcript advocates for personalized approaches that honor client diversity and lived experience. By inviting readers into this conversation, we hope to inspire a shift in how therapists engage with clients-fostering deeper, more meaningful connections. Including former clients as co-authors alongside their clinicians introduces an innovative and humanizing direction in systemic family therapy.

> As I began to apply myself more, my self-esteem rose with the accomplishments that made me feel productive. Making the effort to leave the isolation of my room and coexist in public led to socialization and forming connections, which eventually developed into relationships. Building relationships, setting goals, and taking practical actions to achieve tasks that benefited me ultimately created the momentum needed to feel better about myself.
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> While I believe that biological components should be considered and addressed in certain cases, there seems to be an issue in the psychological

> field where conclusions are preemptively drawn in favor of biological explanations. In reality, many problems can be resolved by addressing trauma and offering practical solutions. Telling someone they have a biological malfunction can lead them to lose hope and believe recovery is impossible. In some cases, it even becomes a justification for their unhappiness, preventing them from taking action.
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> Too often, the symptoms of trauma-normal responses to abnormal experiences-are labeled as internal deficiencies. This approach confuses and misleads individuals in their recovery process. It is far more beneficial to analyze past traumas, identify the resulting core issues, and offer reconciliation through emotional management and goal-setting aimed at restoring contentment. A pathway to recovery with achievable actions is far more healing than endlessly treating symptoms presumed to be permanent and unavoidable. Healing occurs through self-actualization, competency, and willpower. Recognizing our autonomy as individuals is what instils the hope and power to create change (A story in their own words-transcript of a 23-year-old male reflections on this paper, 2025).

In a world dominated by dehumanizing labels and pathologies, we strive to use collaborative approaches that honor the emotional experience of being human. The power of unspoken knowledge and the integrity of personal experiences that, once shared, carry immense weight are remarkable. There is something about keeping certain things unspoken that makes them even more potent. When they are finally shared, it is often done with great trust. In this space of sacred conversations, we are exposed to content that perhaps was never dared to be spoken before.

The solutions formed are held deeply in people's hearts and minds, and what they share remains inviolate. According to Sharma (2023), this process is *"emancipatory"* and reflects both clinical work and research. In her book *Barriers to Recovery from Psychosis*, she outlines how, from the first interactions with mental health clinicians, individuals enter into a process of subjectivation and colonization, where the chance to be seen or to have agency is lost. This introduction leads into a world where foreign maps replace identity and agency.

Our conversations are sacred because they validate the lived experiences of the people we want to help. Being human is an emotional journey-we are meant to feel. Dismissing emotions as *"crazy"* or *"insane"* diminishes the richness and depth of life. Emotions create vivid and colorful experiences. Just as hard times come with good times, we must rethink how we describe and relate to others. A therapy session, a hospital admission, or residential treatment are snapshots of the worst

times of our lives. What and whom define the content and context, and who determines a person's ontology and journey to wellness.

How do we cultivate the awareness that previous pioneers brought to the field, and how do practitioners move forward with it. How do we reconnect with the roots of marriage and family therapy? How do we dismantle the narratives that confined those who have become *"Extraordinarily Normal"* after shedding the Limits of Severe Mental Illness Narratives/Labels? How do we help society, families, colleagues, and practitioners normalize themselves for the others?

In highlighting these concepts, we wish to note the works of Robert Whitaker in *Mad in America* (2002, 2025), *Summing Up the STARDDS Scandal: The Public Was Betrayed, Millions Were Harmed, and Mainstream Media Failed Us All*, and Lawrence Kelmenson's *For-Profit Healthcare Is a Predator; Its Main Prey Is Our Young* (Kelmenson, 2025). *Mad in America*, for some, serves as a space to become extraordinarily normal, as does the work of Kinman and his associates in Canada, along with many others globally.

For example, evolutionary love, a concept introduced by Kinman and colleagues, encourages seeing people through the lens of their lives-a practice once referred to as *"seeing through the local"* (personal comment). It means seeing people as they wish and deserve to be seen. Wanting to be listened to and seen with open hearts and minds is a recurring theme among those who suffer. Our research reflects therapeutic normalcy by incorporating natural conversations about extreme challenges, individual and family needs, and clients' voices being heard.

These approaches reject rigid time constraints and focus on transforming problems and perceived deficiencies into strengths and hope. They emphasize genuineness and transparency between therapists and clients, fostering relationships where all parties see each other as people working together to resolve challenges.

Such atmospheres of care and curiosity, rather than preconceptions or therapist-led solutions, produce sustainable change regardless of previous diagnoses, ethnicity, socioeconomic status, or age. Therapeutic environments devoid of coercion, manipulation, prejudice, or power dynamics-where there is time to truly care and listen-can profoundly reshape the path to healing. (Swim et al., 2023). We can foster a deeper sense of trust and collaboration, ultimately empowering individuals to embrace their own healing journey, while also encouraging clinicians to humanize themselves and actively engage in the healing process alongside those they treat.

## Considering Alternative Perspectives

Our field proposes that therapists can integrate their skills and ethical principles to provide effective therapy for clients. We have heard from our clients that this approach can be counterproductive, as noted. However, we believe that through the therapeutic partnership within conversational therapeutic communities, these variables can emerge collaboratively. Recognizing the diversity and uniqueness of each client and therapist, it becomes clear that Process Ethics cannot be reduced to skill or ethical principles alone.

The aspiration of Collaborative-Dialogical Practices is to ensure our collaboration doesn't inadvertently cause the client to experience more judgment or diagnoses, or feel unheard and invalidated. Therapists achieve this by looking to the client for direction and honoring their goals for each session, which can vary quite a bit. Like other therapeutic actions, transformations are relational. However, our purpose is to explore and gain illuminated understandings of the human experience through genuine and cooperative discourse. We believe in our clients' stories. We are slow to understand and can never fully grasp the thoughts or intentions of another. We do not interpret what they say, nor do we look for symptoms. The goals of therapy are a reflective process. We do not treat people. We engage in conversations and help them find the plans for life that they desire and deserve.

Often our collaborative practices are compared to Rogerian therapy. Harlene Anderson (2002), in *Postmodern Collaborative and Person-Centered Therapies: What Would Carl Rogers Say?* discusses the similarities and differences between the two therapeutic modalities. While Rogers speaks to client-centeredness, unconditional positive regard, and empathy, there are critical differences. In Rogerian therapy, the therapist takes a passive role and follows a set of therapeutic rules, including reframing, providing a correct understanding of the client's experience, and leading the client toward a specific goal or conclusion.

While this comparison is favorable, the differences are significant. In collaborative work, we are not focused on eliminating symptoms or helping clients achieve wellness in a predetermined way. Instead, in collaborative practices, the therapist is actively engaged in exploring what the client wants to happen. We do not view the client as broken or incapable but rather as someone who may be feeling significantly hopeless or lost. We believe in the paradigm of problem determined systems and the social construction of mental health, wellness, and unwellness (Anderson & Goolishian, 1987; Swim et al., 2001).

As mentioned earlier, symptoms are seen as a snapshot of the person. We believe that focusing solely on symptoms ignores the client's self-agency, leading to confusion. The client may question: Are they really as broken as when they first

came to therapy? Does therapy focus on strengths, regardless of the symptoms? When we focus only on one aspect of life, it is easy to feel hopeless. When we are told we are broken, we often believe it. Similarly, when we are told we can never be cured, we often believe that as well (Anderson & Goolishian, 1987; Swim et al., 2024).

Early in the development of collaborative practices, we referred to ourselves as consultants. We wanted to inspire clinicians to look beyond generalized treatments and research. These attempts often limit us by seeing people through a particular lens, one that may be foreign to the client. However, clients are often willing to learn any theoretical language in hopes of becoming asymptotic and reclaiming their lives.

We recall the young woman described in *Multiple Voices: Stories of Rebirth, Heroines, New Opportunities, and Identities* (Swim et al., 1998) and Anderson (1997), whose experience reminds us of the 12-year-old's testimony in 2024, where both referred to these clinician-created *"foreign concepts."* He talked of coercion and confinement. She said, *"What are food contracts, and why do they have to blame my family? I know why I decided not to live. Life became tormenting, especially through losing my life to so many doctor appointments. There were many reasons I was unhappy, but the biggest was being benched from my team. I was one of the best, and I had to sit and watch others play. My times in the hospital only broke me down, and I saw no way out"* (Swim et al., 1998).

It is difficult for those not introduced to social constructionism to see how change can be simple. We have operated from these premises since the beginnings of marriage and family therapy. Harry Goolishian was one of the first psychologists to sneak a family member into a hospital for therapy (Anderson, 1997). In many ways, he and Harlene are responsible for this opportunity to share these case studies (Anderson & Goolishian,1992).

The purpose of our research is not to generate reliability or to find skill sets for a traditional new model of learning. Instead, it provides opportunities to hear and appreciate stories of human suffering and learn how transformation occurs. Through hearing these stories, we see practitioners and clients moving from deficiency paradigms to appreciative inquiry, where stories of hope abound (Swim, 2003).

> *"With the voice of the subject moved to the forefront, designs are created to implement hearing the multiple opinions and realities that emanate from the interview process".* (McNamee, 2000).

We are not trying to present a singular truth but an abundance of ideas to attempt to understand the Other. We are honored by the polyvocality of people in this

world. It is hoped that the reader gains a new appreciation for how these case studies illustrate the cessation of mental illness symptoms and the freedom to engage with stories of strength, grit, resolve, and transformation.

We thank the members of *Metalogos* for helping us create this article. Their work is vital to our field, as are the contributions of colleagues and organizations not mentioned. It is the search for what is right and good that remains paramount.

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