The juice is in the detail: an affordance-based view of talking therapies

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Abstract

The burgeoning interest in enactive paradigms of perception and cognition offers an opportunity to reconsider how we conceive psychotherapy – 'talking cures' as functioning. In the past many therapy modes have focused on the over-riding importance of giving insight to the patient; knowing what caused the 'illness' provides a solid way to deal with it. Over the past half-century, more pragmatic forms of therapy focusing on behaviour change through adjusted thinking (cognitive behavioural therapy) have become commonplace.

But what does it mean to 'change our thinking' from an enactive perspective? If perception and cognition are direct engagement with the environment, what is changed by a therapeutic conversation? One answer lies in the idea of affordances (Gibson, 1979) – the relationships between features of the environment and the abilities of the animal/person to interact with them. Recent views of affordances as dynamic (Chemero, 2009) make even clearer the ways in which these factors may change and evolve.

The paper compares an affordance based view with practical examples from solution-focused brief therapy (SFBT), where recent developments have pointed to the power of developing detailed descriptions of 'better futures' and 'past instances' (Shennan & Iveson, 2011). In such detailed conversations, everyday and overlooked events such as hugging a loved one when they return from work can become significant possibilities for building recovery. The paper will show examples and how such detailed descriptions can develop new affordances for clients.

One key aspect is how these features emerge and are developed during the therapeutic conversation. Do they come from the therapist or the client? How can the therapist help the client develop new affordances that are relevant without intervening with their own ideas about 'what ought to happen'? The ways in which conversations about affordances can be seen to connect to strong and modest ideas of narrative development will also be explored briefly.

Introduction

In a symposium entitled 'Reconceiving Mental Illness', we are invited to think broadly about the topic. I intend to take this invitation seriously and present a novel view of both mental illness and how to enhance mental health. These topics have been discussed for centuries, and I cannot hope to present the full historical discussion here. Rather, I intend to set out some key points and then present a philosophical and practical case for a new way to look at mental illness though affordances.

One of the great truths (and for some, mysteries) of the mental health profession is that most if not all forms of talking therapy have broadly similar effectiveness. The huge metastudy of Wampold (Wampold, 2001) showed that not only do different therapy modes have similar effectiveness, and drew attention to the overall importance of 'common factors' (first listed by Lambert (Lambert, 1992)). These include therapeutic relationship/alliance, hope/expectancy, client factors and extraneous events. Despite this, the therapy world has continued to debate different models and approaches. One shortcoming of the Wampold study (and of most outcome studies) is the lack of consideration of the duration of therapy as of key interest. If everything 'works', then what works faster? During the heyday of psychoanalysis this was an unasked question, since it was common knowledge that mental disorders took years to deal with. During the past decades, however, there has been a rise in 'brief therapies', where the focus is on helping the client using 'as few sessions as possible' (Steve de Shazer, 1985). Such therapies typically take a handful of sessions to work (Franklin, Trepper, McCollum, & Gingerich, 2011).

There has been a bizarre obsession relating effective treatment to long-term therapy over the years, mainly due to the assumptions of psychoanalytic practitioners in the first half of the twentieth century. Clients and practitioners have grown more pragmatic in recent times, and now brief therapies are more valued. In a system such as the UK National Health Service where limited numbers of practitioners are available, the impact of shortening treatment can be huge. Lord Layard and colleagues (Layard et al., 2006) showed the huge impact of depression and other mental health problems – over a million people off work on incapacity benefit, in some cases waiting years to see a therapist who could help them in relatively short order (Layard mentions Cognitive Behavioural Therapy and 16 sessions). If the duration of therapy can be reduced from 16 sessions (itself brief by many standards) to closer to 4 sessions as shown by the latest brief therapy research (Shennan & Iveson, 2011), then four times as many people can be helped – even without recruiting extra therapists.

What is mental illness?

This is a much contested question, about which there is little space to go into detail here. It looks so obvious at first, but unpicking the issues leads to considerable complication and confusion. The usual contrast is with physical illness – nobody would say that a broken leg was a mental condition. A stroke – a blood clot in the brain – can lead to speech impediments that can appear 'mental' (but probably should not be treated as such. Is pain mental or physical? Kendler (Kendler, 2008) lists some of the key issues as causation (what causes mental illness, and in particular can it all be reduced to the brain, as some reductionists hope), the role of phenomenology and personal experience (which demands contact with the first person client situation rather than the third person expert) and nosology (the way that mental illnesses are classified). At present a pluralist view – different kinds of explanation are relevant – seems in the ascendant.

In general terms, most people think of mental illnesses as 'in the head'. One typical quote from the BABCP website ("What is CBT?," n.d.) says:

"During times of mental distress, people think differently about themselves and what happens to them. Thoughts can become extreme and unhelpful. This can worsen how a person feels. They may then behave in a way that prolongs their distress."

This shows the assumption that thoughts precede behaviour – typical of the cognitive school of thought. This is so ingrained in our society as to go almost unchallenged – something 'inside' the person then appears on the 'outside' as behaviour. It is this assumption that the enactive paradigmn seeks to challenge.

The enactive paradigm – direct engagement

The enactive paradigm of perception and cognition is probably the most radical of the '4Es' (Rowlands, 2010) (embodied, extended, embedded and enactive) cluster of approaches which stem from the original work of Varela, Thompson and Rosch (Varela, Thompson, & Rosch, 1991). Briefly, rather than organisms taking in information ('perception') and then using it to make decisions about behaviour ('cognition'), the entire perception/cognition process is seen as a direct engagement with the environment. It is easy to see how this might happen for a blind person exploring a fruit bowl with their fingertips (or a pavement with their stick), but there are also indications and theories about visual perception based around sensorimotor rather than image-building processes (O'Regan & Noë, 2001).

Whereas the cognitive paradigm sees mechanisms in the head – either physical or mental – the enactive paradigm sees no need to posit mental representations. The world is its own representation, and carrying another around 'in our heads' would seem to be an unnecessary assumption. Indeed, Radical Enactive Cognition (REC)(Hutto & Myin, 2013), the most extreme variety of enactivism, does away with all mental content. Another key distinction is the position of experience – our first person experience and awareness of what is happening to us. From a cognitive standpoint, experience is an epiphenomenon – a by-product of cognitive activity in the mind or brain (which are routinely superposed). In enactivism, experience is a primary element of cognition and is to be taken seriously in any description of 'mental' activity(McGann, De Jaegher, & Di Paolo, 2013). Note that this paper makes no claims as to the success of the radical enativist project – the conclusions hold of up any kind of enactive and ecological framework.

Role of the brain – the task/tool metaphor

This switch in emphasis can lead some readers to think that enactivism posits no role for thinking or the brain. This is of course incorrect. The brain is a vital organ, and removing it will seriously impede the thinking of the subject involved! Rom Harré's task/tool metaphor (Harré & Moghaddam, 2012; Harré, 2001) is a key way to understanding a way to look at the role of the brain from an embodied/enactive perspective.

Imagine somebody using a spade to dig a ditch. The person is using the spade to dig the ditch. The task is digging, and the tool , used by the person, is a spade. The spade does not dig the ditch – the person digs the ditch, using the spade. We could (and should) study spades – after all, a well-designed spade will be a great help in digging the ditch. We can (and perhaps also should) study digging. Note the studying spades is not the same as studying digging, and to study digging we will need a person who is digging to make any progress in our study.

Now switch the task and tool to thinking and the brain. A person uses their brain to think. The person thinks, not the brain. We could (and should) study brains. However, to study thinking will require a person to do the thinking, in the same way that a study of digging requires a digger. To

take on the idea that a brain thinks (as opposed to a person) is to commit what Maxwell Bennett and Peter Hacker call the 'meriological phallacy' (Bennett & Hacker, 2003) – applying to a part something which should only be applied to a whole. In this case the brain is a part of a person, and a person thinks (remembers, fears, loves, forgets, sees, etc), not a brain.

Memory can be treated the same way. Some people, including St Augustine (Augustine, 2006) and Jerry Fodor (Fodor, 2005) assume that memories must be treated like mental representations, carried around for reproducing at the desired moment. An enactive perspective makes clear that remembering is an activity of a person (not a brain), and involves an active constructive process – a re-membering, a putting together (as opposed to dis-membering, to pull apart). This view is being accepted in both scientific (Schacter & Addis, 2007) and philosophical (Moyal-Sharrock, 2009; Myin & Zahidi, 2014) circles.

We might note that taking the task/tool metaphor seriously already offers a line on what constitutes a mental illness. One could imagine a separation between illnesses of the brain (for example brain tumours, strokes and even Alzheimer's disease) and diseases of the person (for example depression, anxiety). This is not to say that people are not incapacitated by brain diseases – far from it. It is interesting to note that Alzheimer's disease is formally classified as a mental illness in both the USA (within the DSM V (American Psychologyical Association, 2013)) and the UK (under the Mental Health Act 1983), which is probably a good thing in terms of sufferers getting practical help and protection under the law, but raises an interesting philosophical question.

The brain and the person are not of course mutually exclusive domains. Activities carried out by a person will change their brain activity, and changes to the brain (by drugs or deep brain stimulation, for example) will change the person's experience. It might be better to think of these as two routes to treatment – some disorders might respond better to one than the other.

A brief history of affordances

This paper promises an affordance based look at talking therapies. This section will take a look at affordances and the development of the idea over the past decades.

The term 'affordance' was originally introduced by ecological psychologist JJ Gibson (Gibson, 1977, 1979) in the late 1970s. Gibson's theory of direct perception, a precursor to the enactive paradigm, has three headlines:

- Perception is direct
- Perception is for action
- Perception is of affordances

Affordances are an interaction of an animal and its environment – what kind of opportunities for interaction the environment is offering the animal, relating to the animal's sensorimotor capacities. A small tree branch, for example, may offer a bird somewhere to perch and observe the surroundings, whereas the same branch might offer a person a handhold, a chance to gather kindling for a fire, a back scratcher, a drumstick, a subject for a sketch and so on. The affordance is neither a property of the animal or the environment, but in the interaction of both. Gibson himself defined affordances in this way:

> *[An] affordance is neither an objective property nor a subjective property; or it is both if you like. An affordance cuts across the dichotomy of subjective-objective and helps us to understand its inadequacy. It is equally a fact of the environment and a fact of behaviour. It is both physical and psychical, yet neither. An affordance points both ways, to the environment and to the observer. (Gibson, 1979, p 129)*

Many people read Gibson as saying that the affordance is there to be discovered by the animal, in suitable ambient light. Varela, Thompson and Rosch (Varela et al., 1991) note that embodied perception is not 'direct detection' but is sensorimotor enactment, 'dependent on histories of coupling'. We might think of this as a learning process. Varela, Thompson and Rosch are also keen to emphasise the co-determination of animal and environment.

> *"A cognitive system is functioning adequately when it becomes part of an existing ongoing world (as the young of every species do." (p 207)*

Anthony Chemero takes the idea of affordances on another level (Chemero, 2009) with his 'affordances 2.0 model'. Having already refined his definition in an earlier publication (Chemero, 2003) to be about the relationship between abilities of the animal and features of the enviroment (stressing further the learning element involved in developing affordances), he offers a dynamical model working on two timescales – developmental and behavioural. This shows even more clearly how abilities and affordances co-develop over both the life of an animal and over longer timescales.
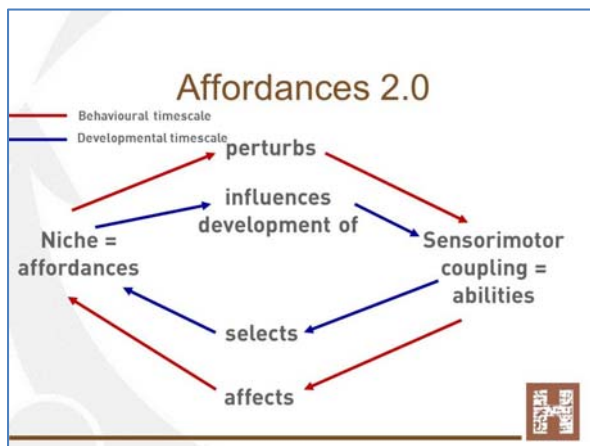
 Affordances 2.0 (after Chemero, 2009)

Sanneke de Haan, Erik Rietveld and co-workers(de Haan, Rietveld, Stokhof, & Denys, 2013) have further developed these ideas by contrasting the 'landscape' of affordances with the narrower 'field' of affordances for an individual in a concrete situation.

> *"We distinguish between the* landscape *of affordances and a* field *of affordances. The* landscape *of affordances refers to all the possibilities for action that are open to a specific* form of life *and depend on the abilities available to this* form of life*. In our human case this notably includes socio-cultural practices. The landscape of affordances thus describes the so-called "ecological niche" of a form of life. A particular aspect of the environment, say a tree, can play a role in the landscape of affordances of multiple forms of life. Von Uexküll (Von Uexküll, 1920)*(Von Uexküll, 1920) *gives the famous example of an oak tree: for a rabbit it affords digging a hole between its roots, to a woodworm it provides food, for a person it could*

afford shelter from sun or rain, or cutting. The field *of affordances refers to the relevant possibilities for action that a particular* individual *is responsive to in a concrete situation, depending on the individual's abilities and concerns. The field of affordances is thus a situation-specific, individual "excerpt" of the general landscape of affordances."* (from De Haan et al, 2013)

The phrase 'form of life' in this paragraph is a nod back to Wittgenstein's (Wittgenstein, 1953) adoption of this phrase to signify a context where language has a (shared) meaning. The authors then develop a three dimensional model to describe the extent of a field of affordances. The three dimensions are:

- Width (broadness of scope and choice of options)
- Depth (temporal – now and in the future, with anticipatory affordance-responsiveness)
- Height (relavance/important of affordances, relating to motivation and 'affective allure'

De Haan et al, who are seeking a way to describe the changes produced by deep brain stimulation treatment on sufferers from Obsessive Compulsive Disorder (OCD), tentatively sketch out how a field of affordances may appear in three different cases:

FIGURE 1 | Sketch of different fields of relevant affordances.
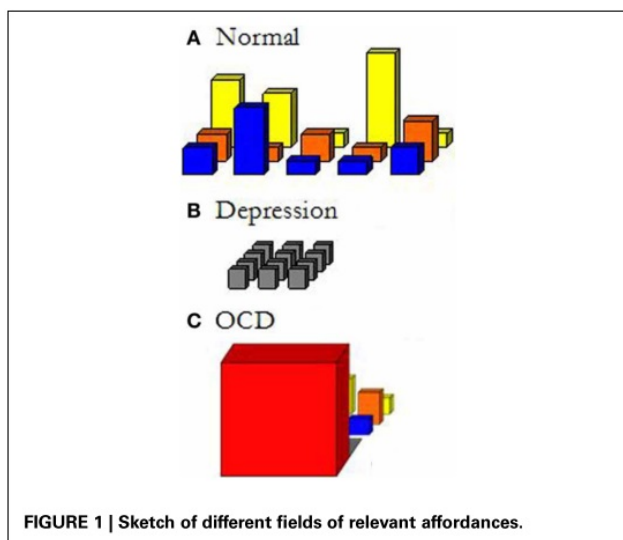
(From De Haan et al 2013)

The 'normal' field of affordances show graspable variety in all three dimensions. The 'depression' verion shows everything looking the same – there is little in the way of meaningful choice or possibility of difference. The third diagram, reflecting the OCD case, shows one affordance (which may relate to washing hands or cleaning the house, for example) dominating the field in terms of importance. Note that these graphs are intended to be illustrative.

An enactive view of mental illness

German psychiatrist Thomas Fuchs offers an interesting way into a general discussion about enactivism and mental illness. In a paper (Fuchs, 2013) examining depression not as an inner and individual complaint, but as a detunement/disturbance ('Verstimmung') of 'the resonant body that mediates our participation in a shared affective' (which is very much stated in embodied and

enactive terms), Fuchs harks back to phenomenologist psychiatrist Jan Hendrick van den Berg's pithy aphorism(Berg, 1972):

> *The patient is ill; this means, his world is ill.'*

Fuchs elaborates on this position:

> *In this sense, the illness is not in the patient, but the patient is in the illness, as it were; for mental illness is not a state in the head, but an altered way of being in the world. (Fuchs 2013, p 222)*

Taking the statement 'the world of the patient is ill', it is easy and tempting to fall back into a cognitivist picture that the world of the patient is inside the head of the patient. From an enactive perspective, the world of the patient is 'out here', in the interactions of the patient. The recent developments in the theory of affordances described above now offer a way to expand on this idea in more concrete terms.

The 'world of the patient' is the patient's field of affordances. Remember that this is an excerpt from the total landscape of affordances open to the patient's form of life. This is dynamic on many levels – including behavioural and developmental. So, if we take those mental illnesses best described as conditions of a person (as opposed to a brain disease), we can tentatively define this form of mental illness as:

A persistent Verstimmung (disturbance/detuning) of a field of affordances

These terms are carefully chosen:

Persistent: not very temporary – we all have temporary disturbances in our worlds and deal with them by everyday actions. We feel a bit miserable and decide to go out for a walk and see some friends, for example. These are everyday ups and downs, and are dealt with routinely most of the time. Only if the 'ordinary' ways of dealing with something prove ineffective can we start thinking in terms of illness. This idea was first put forward by John Weakland and colleagues at the Mental Research Institute, Palo Alto in the 1970s (Watzlawick, Weakland, & Fisch, 1974; Weakland, Fisch, Watzlawick, & Bodin, 1974) and is still sound.

Verstimmung: This is a German word which has a number of meanings difficult to entirely sum up in English. These include disturbance, detuning, and leaving a bad mood. This is not a breakage – there is a sense in which the disturbance can be corrected. This is not, of course, referring to a bad mood which 'accompanies' the illness, the Verstimmung is key to the whole picture.

Field: This refers to the field of affordances relevant to this person in this context. This inevitably brings a first person perspective into action – different people will naturally have different fields of affordance, and in particular the therapist/practitioner will not be able to take on the client's field of affordance.

Of affordances: This is, again, not in the person or the environment (though it is hard to speak of them in those terms with the limitations of English grammer, as in the paragraph above) but in the relationship between the person and their environment, as shown in possibilities for action and engagement.

An affordance based view of talking therapies

Psychotherapy has been characterised (and caricatured) as 'two people talking, trying to figure out what one of the wants'. All talking therapies have in common at least the talking element (though the topics of the conversation very dramatically between approaches). We can also recall the findings of Wampold (Wampold, 2001) that all talking therapies are about as effective as each other in pure outcome terms.

What has never been done, as far as I know, is to look at talking therapy explicitly in the way it stretches and changes the client's field of affordances. On this basis, therapies which seek to address mental distress by a focus on long-passed causalities such as childhood trauma and familial relations might be expected to take a long time to work, whereas therapies focusing more on details of the a better future might be expected to bring more rapid progress.

If we are to look at talking therapy as helping to stretch the client's field of affordances in useful ways that connect to progress, we might expect to look for:

- The therapist taking the client as an active participant in the treatment
- The therapist taking the first person perspective/descriptions very seriously
- The therapist not attempting to discover what has caused the problem, but rather establishing a conversational narrative around progress in the past, present and future
- The conversation being focused on small details of a 'better world' – signs that things were improving.

One might expect that such a stretching of the field of affordances might have an emergent quality about it – sometimes neat, sometime messy, sometimes clear, sometimes confusing. To stretch a field of affordances is to stretch the world of the client – which is not the same as to provide key steps for action to the client. The next steps will play out in the new world – which may have a big impact or very little impact.

Might such a therapy be effective? Well, there is already one that works in much the above fashion which is indeed effective – Solution Focused Brief Therapy.

Solution-Focused Brief Therapy through an affordance lens

Solution-Focused Brief Therapy (SFBT) was devised by Steve de Shazer, Insoo Kim Berg and colleagues at the Brief Family Therapy Center in Milwaukee WI in the 1980s (S de Shazer, 1988; S de Shazer et al., 1986). It has since spread around the world, being widely used in education, social work, organisational change as well as therapy, with a significant evidence base (Franklin et al., 2011; Macdonald, 2011). The approach appeals to those who value a pragmatic and skilful approach to building progress, but it has not been widely supported by psychiatrists and medical professionals for whom it lacks proper 'theoretical' grounding. De Shazer, Berg and colleagues started with the interactional brief therapy approach devised by Weakland and others, and experimented with trying to make it both more minimal (in terms of the therapist's model and theory) and more efficacious (in terms of fewer sessions to help clients reach a position where they could carry on under their own steam, without continuing therapy). In this way, the practice could be said to be pragmatically and empirically rooted.

The latest and most stripped down version of SFBT is that proposed and practiced by the BRIEF group in London (Shennan & Iveson, 2011). In a typical first session, the therapist will:

- Discuss 'best hopes' of the client for the work together – a theme for the project
- Elicit a description of a 'preferred future' – with these best hopes realised
    - Tomorrow (usually)
    - Detailed and observable (referent)
    - From client's perception and relevant others' positions – spouse, colleagues etc
    - Suppose… all about how it could be, not how to get there
- Elicit 'instances' – in the past and/or present – of the preferred future happening already
    - Often using a scale from 1-10
    - Details, details, details…

In follow-up session(s), the therapist will ask about 'what's better?' since last time, seek more details about how the client managed to do that, and summarise progress so far. Using this model, Shennan and Iveson report (over an admittedly small number of clients) an average therapy duration of under four sessions.

It is generally found in practice (by me and others) that getting these conversations down into small tiny details is important. SFBT co-founder Insoo Kim Berg used to advise therapists learning the approach to value '$5 words' (very small concrete and everyday words) over the '$5000 words' of abstraction and professionalism typically used valued by self-important experts. I want to put forward the idea that these details are connected with stretching the field of affordances.

A real-life example – 'Mary and the cuddle'

To give a brief flavour of an SFBT session, I include here a very short excerpt from a real conversation. 'Mary' (not her real name) has been referred for treatment following long term depression and suicide bids. This is her first session. The therapist (Chris Iveson of BRIEF) is in the middle of helping Mary to describe a better tomorrow, when an imagined miracle has realised her self-defined hopes of 'the past not pulling her back any more'. After about 25 minutes, they reach a point in the day when Mary's partner Jeff will return from work. (This very short excerpt was presented at the conference.)

Therapist: And what is the first thing he would notice when he got home, even before you spoke? What is the very first thing?

Mary: I would be… instead of a worried, stressed, anxious look on my face maybe a smile.

Therapist: Okay. And what would be the first thing you would notice about his response even before he spoke?

Mary: I think my body language would just be so… you know normally he has to come looking for me whereas I would imagine that I would be open to go and cuddle him instead. You know? So…

Therapist: Would he faint or…?

Mary: Possibly, yeah, absolutely. You might have to have the paramedics on standby, yeah. I think it would be shock, but pleasant shock rather than shock shock.

Therapist: So where would that be? Where would you be cuddling him?

Mary: I would imagine that… because I do almost always hear him pull up. I never go to the door. I let him come in through the door and come find me. Whereas I would probably go find him.

Therapist: Okay, so that would be a different…

Mary: Yeah.

Therapist: And what would you notice about the way you cuddled him that fitted with this sense of peace and pleasure, of being you?

Mary: He describes sometimes that when he asks me for a cuddle… he said 'When I ask you for a cuddle…' and I do give it to him, he goes 'You are rigid and you almost… you cuddle me but you are pushing me away.' So I would imagine that it would be a much more natural, open embrace where I felt relaxed and safe enough to do that. Not rigid and tight.

Therapist: And what would you notice about his response to your cuddling and that kind of relaxed…?

Mary: I think that he would be delighted with how it felt to have a cuddle that didn't feel like he was a) having to ask for or b) being pushed away from.

Therapist: And what would you notice about his arms?

Mary: I think they might be quite tight around me and probably hold me for longer than normal.

Therapist: Okay. And what would you notice about how you handled that?

Mary: I think it would be quite difficult because you get so rehearsed in how you do things. Whether that be good or bad, that's how you are. So I think it would be quite a new experience to have that.

Note that the therapist is not himself contributing to the details. He is rather asking questions which help Mary come up with her own details. He asks questions suchn as:

- And what is the first thing he would notice when he got home, even before you spoke?
- And what would you notice about the way you cuddled him…
- What would he notice about you?
- And how would you respond, when he did that?

These questions are all in the context of Mary describing a future (tomorrow) that is both utterly mundane and yet transformed by the realisation of her own hopes. She is stretching and changing her world in response to the therapist's questions – and because the talk is of a better future, the stretching is in a potentially useful direction. (We might note that many therapeutic approaches

take a lot of time talking about what happens when the problem occurs or started, which might be stretching the world in an unhelpful way.) Note that these questions themselves are the treatment – they are not gathering information for the therapist to deploy later in some intervention.

For clarity, some of the affordances discussed in the excerpt above might be:

- The sound of Jeff pulling up as an opportunity to go and meet him
- Jeff's appearance as an opportunity for cuddling in a particular way
- The cuddle as a longer engagement rather than something to be broken off

I say these 'might' be affordances in the conversation. We cannot say from a third person perspectives what are new or important affordances - we would have to ask Mary herself. And I am not saying that it's now simply a matter of Mary going and doing these things – her world has been stretched, her field of affordances altered, and now life will go on. It is only later that the impact will be clarified.

Previous versions of SFBT have focused on the conversation as a route to the therapist being able to establish tasks or actions for the client to help them 'do more of what works'. The latest thinking from BRIEF, the author (Jackson & McKergow, 2007) and others is that such a direct interventionist approach is unnecessary – either asking the client what they are minded to do next, or even simply leaving that out of the conversation altogether seems even more effective. It is worth noting that when the client's description is as detailed as the example above, all sorts of tiny actions and reactions have become possibilities in a revised world. This supports my hypothesis that the world-stretching is the key, rather than any post-rationalising that may go on between client and therapist (though such further conversation may strengthen the new world in some way).

Talking about affordances and building affordances

We might legitimately ask about the connection between describing affordances and creating/using them. From a cognitive standpoint there is all the difference in the world between talk and action. From an enactive standpoint, the difference is considerably reduced. In order to describe something, the client has to somehow put themselves into a different world. And once it's been described it can't be undescribed – echoes of the social constructionist idea of Ken Gergen that we carry around all our previous interactions as potentials for action (Gergen, 2013). There is even a view that from the first person perspective of the client, there is no fundamental difference between information through language and through visual and corporeal channels (Barrett, 2011; Wilson & Golonka, 2013). There is no space to go further into this fascinating position here.

One point worth making in closing – how this position relates to a narrative perspective, itself a popular strand of therapeutic thinking and practice with similarities and differences to SFBT(White & Epston, 1990). There are some who hold 'strong narrative' views that everything in life should be viewed in narrative terms (Rudd, 2012). Others, with whom I would align my position (Hutto, 2014) take a more modest view, embracing the idea that narrative offers a useful view rather than an overarching mechanism. This is consistent with the task/tool metaphor for the mind, where discourse is a key but not exclusive element.

Conclusions

This paper has covered a great deal of ground very quickly and lays out a potential agenda for investigation. The key points are:

- Affordances offers a new perspective for talking therapies
- There is intitial evidence that this perspective is useful on a practical basis
- This may go some way to show why some therapies take a lot longer than others
- This perspective offers a researchable hypothesis for even more effective forms of talking therapy.

Acknowledgements

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