CHAPTER 11.
WRITING FOR STABILIZATION AND WRITING FOR POSSIBILITY: THE DIALECTICS OF REPRESENTATION IN EVERYDAY WORK WITH VULNERABLE CLIENTS

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About 25 years ago, Charles Bazerman (1997) put forward a powerful argument for understanding the foundational role of discourse in the structuring of professional activity systems. As if to drive the point home, in the same journal issue, Carol Berkenkotter and Doris Ravotas (1997) published a paper in which they showed how in psychiatric consultations the client's initial oral account—which the authors characterize as emic—is transformed into a decontextualized etic record, replacing active verbs with nominalizations that allow the classification of the case in accordance with the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, to be turned into a billable diagnostic category.

Similar shifts from accounts and narratives expressing clients' personal concerns to official records have been analyzed by Hugh Mehan (1993) in the handling of school students' learning disabilities. I have called the outcome of this shift *stabilization knowledge* (Engeström, 2007), indicating that it involves the representation and classification of an unruly idiosyncratic bundle of problems in terms of well-known categories that allow the formation of a *case* as a bounded and relatively stable entity that can be handled according to standard guidelines and procedures. Stabilization has been aptly characterized by Brian Smith:

> Stabilization is not just a process of standing back in order to let the object quieten; it also involves reaching out and bashing the object into shape, so that it will be stable enough to register. . . . The stuff of objects is by nature unruly. It is a collaborative achievement for them to hold, or be held, still enough to be brought into focus. (1996, p. 300)

So stabilizing category knowledge is used to turn the problematic into a closed phenomenon that can be registered, calculated, and pushed around rather than transformed. Stabilization is unavoidable, but stabilizing categories such as diagnostic labels tend to become stigmatic stamps. What is missing in the pioneering studies of Berkenkotter and Ravotas and Mehan on the shift from emic to etic is the possibility of going beyond stabilization.

Much of my work in the past 25 years has been focused on designing and implementing ways and instruments for making another shift, from stabilization to *possibilization*, or possibility knowledge (for a philosophical discussion of possibilization, see Epstein, 2019). The shift to possibilization means that the client's needs are examined by means of collaborative negotiation, against the background of their history and emergence. The critical component is the use of *representational instruments* that allow the client and the professional to depict the client's possible *movement* from his or her past and current positions toward a radically empowered position in which the client and the professional as well at times has a qualitatively different grasp of their activity. This is a shift toward recontextualized and prospective modes of representation, writing, and action.

In what follows, I will first summarize the characteristic features of the shift from emic to etic representations in encounters between professionals and vulnerable clients. I will then discuss the available literature on possibilization and possibility knowledge. This leads me to introduce three types of representational instruments developed and used for possibilization in my own studies and those published by others. These three types are *written agreements, four-field models,* and *pathway representations.* I will show how each one of these types of representation can work to open up and support discursive and practical re-orientation toward dynamic possibilities in professional-client interaction. I will conclude the chapter with a discussion of possible transitions and iterative movement between the contextualized-emic, the decontextualized-etic, and the recontextualized-prospective modes of representation and writing, arguing for a politics of deliberative shifts in representation.

FROM EMIC TO ETIC

The conceptual pair of emic and etic was initially coined by Pike (1954). He pointed out that the study of phonemics involves examination of the sounds used in a particular language, while phonetics attempts to generalize from studies of individual languages to universals covering all languages. By analogy, emic categories are culturally specific while etic categories are culturally universal.

The shift from the client's contextual and emic account to the professional's decontextualized and etic record may be summarized with the help of Figure 11.1.

	CLIENT'S *EMIC* ORAL ACCOUNT	PROFESSIONAL'S *ETIC* WRITTEN ACCOUNT
LINGUISTIC PREFERENCE	ACTIVE VERBS	NOMINALIZATIONS, INCLUDING NUMERALLY BASED CATEGORIZATIONS
PURPOSE AND FUNCTION	EXPRESSION OF CONCERN	STABILIZATION
GENERAL QUALITY	CONTEXTUALIZED, EMIC	DECONTEXTUALIZED, ETIC

Figure 11.1. The shift from emic to etic (Berkenkotter & Ravotas, 1997)

Berkenkotter and Ravotas (1997) showed that that nominalizations, such as names of diagnostic categories, play a critical role in the professional's move into the decontextualized mode of etic representation. Mehan (1993) pointed out also the frequent use of numbers, such as test scores, along with and as justification for nominalizations.

The shift summarized in Figure 11.1 serves the purpose of stabilization or "blackboxing controversies" (Berkenkotter & Ravotas, 1997, p. 258). It turns the client's idiosyncratic worries into a billable diagnosis that can be quickly and efficiently referenced and included in statistics.

It is also fairly common that professional communities develop sweepingly general "insider" categories to label problematic cases. Examples include the category "GROP patients" (Getting Rid of Patients) observed by Terry Mizrahi (1985) in hospitals and the category of "heartsink patients" (O'Dowd, 1988; Moscrop, 2011) widely used among general practitioners in the UK.

POSSIBILITY KNOWLEDGE AND POSSIBILIZATION

There is little literature on possibility knowledge or possibilistic thinking. A recent paper by the management scholars Matthew Grimes and Timothy Vogus (2021) is an exception. These authors define possibilistic thinking as "a cognitive practice which . . . involves the systematic deconstruction and interrogation of the assumptions upon which existing solutions are based as well as the subsequent development of new 'worlds'" (Grimes & Vogus, 2021, p. 2). As this definition does not clearly distinguish possibilistic thinking from other kinds of creative thought, it needs to be elaborated and specified further.

In interactions between professionals and clients, possibility knowledge or possibilization as a mode of representation depicts the client's possible movement from their past and current positions toward a radically empowered position in

which the client has a qualitatively different grasp of their activity. This emphasis on putting the object (client's situation or position) into movement stems from the object-oriented stance of cultural-historical activity theory and from Lev Vygotsky's dynamic conception of the zone of proximal development as a zone of possibilities (Sannino & Engeström, 2018). The first step toward possibilization understood in this way often requires breaking away from a closed category whose inhabitants are doomed to stigma, stagnation, and marginality (Engeström, 1996).

To achieve possibility knowledge, one needs a new instrumentality, or a new politics of representation, to use Mehan's (1993) terminology. The core of such a new instrumentality consists of representations of transitions across the past, the present, and the future. The transitions are understood as actions taken by the client and by those involved in shaping the client's services. Tracing and projecting transitions destabilizes knowledge, puts it in movement, and opens up possibilities (Engeström, 2007). This concept of possibility knowledge has subsequently been utilized by Martin Kramer (2018), Kristiina Kumpulainen et al. (2018), Anna Rainio and Riikka Hoffman (2021), Helena Thuneberg et al. (2014), and Keiko Yasukawa et al. (2014), among others.

Transitions and projected actions can be depicted in multiple ways. In the following, I discuss three alternatives. The first type is written agreements negotiated between the professional and the client. An example of this is the mobility agreement developed in the home care services for the elderly in Helsinki, Finland. The second type is four-field models that depict zones of proximal development for an activity. An example of this is the recent interventionist research on expansive learning among preservice bilingual teachers conducted in New York. The third type is pathway representations. The example is homelessness pathways developed in ongoing interventionist studies on the eradication of homelessness in Finland, conducted by Annalisa Sannino's RESET research group.

WRITTEN AGREEMENTS

Among elderly home care clients, the loss of physical mobility is a central factor behind the erosion of agency and increasing social exclusion. Interventions aimed at maintaining and improving the clients' mobility are therefore very important as possible sources of revitalized agency. However, maintaining and improving the physical mobility of the client is commonly not part of the daily tasks of home care services. The elderly home care client's possibilities of improving their physical mobility are thus usually left unexplored.

Within our project "Preventing social exclusion among the elderly in home care in the City of Helsinki," researchers and practitioners developed a

new instrument named the Mobility Agreement (Nummijoki & Engeström, 2009). The Mobility Agreement is aimed at contributing to the home care client's functional capacity and physical mobility through physical actions planned and executed with the support of the home care worker. Jointly negotiated and approved by the home care client and the home care worker, the Mobility Agreement facilitates the initiation, follow-up and evaluation of regular physical exercises embedded in the daily chores of the client's life at home. As an artifact, the Mobility Agreement is a printed form which the client and the worker together fill with an assessment of the client's condition and a plan of specific mobility exercises to be performed by the client either jointly with the worker or alone. The agreement is supported by an illustrated booklet that graphically displays and explains a variety of possible exercises. Today the Mobility Agreement is systematically implemented in the municipal home care services of Helsinki, and its implementation has been analyzed in a number of studies (Engeström et al., 2012; Engeström et al., 2015; Nummijoki et al., 2018).

I will examine the possibilization potential of the Mobility Agreement with the help of two cases. In the first case, the client was an 86-year old woman. The client felt that her mobility had deteriorated, and due to dizziness, and she did not dare to walk alone outside her home. The client had a Mobility Agreement according to which her mobility was systematically supported by means of taking the trash out together with the visiting home care worker. In this visit, the client and the home care worker took the trash out together. After that, the client and the home care worker had a lengthy conversation about the client's life and care. Toward the end of the conversation, the home care worker took up the taking out of the trash.

> **Home care worker**: Yes, and then there is the taking out of the trash bag every time the home care visits you. Do you at least in that situation go out and move? Each time when home care visits, do you take out the trash bag with them?
>
> **Client**: No, I don't. They have taken it themselves.
>
> **Home care worker**: Oh really. Somebody has taken it out for you?
>
> **Client**: Yes.
>
> Home care worker: Well, well.
>
> **Client**: Many of them have taken it out. The other day I accidentally asked a young guy who brought me the food, I asked if he would take out the trash bags. He said that it is not their job. It might not be, indeed.

> **Home care worke**r: No, it is not their job, they just take care
> of the meals.
>
> **Clien**t: I said sorry about that.
>
> **Home care worke**r: But it would be good for you to always go
> with them to take [the trash bags] out. It does not take a long time.
>
> **Clien**t: Yes, I have taken it occasionally, then some relative
> may come to visit and ask if I have any trash. I say look
> around if there is any.
>
> **Home care worke**r: Well, . . . we have agreed that we won't go
> and take out just one old newspaper. But it would be good to
> keep it regular, so that even if the home care worker offers to
> take out [the trash bag], you just say that let us go together.
>
> **Clien**t: That is right, yes.
>
> **Home care worke**r: So you get to go out a little.

The exchange was important in that the trash bag triggered a critical examination of the actual practice in relation to the mutually accepted Mobility Agreement. The critique concerned both the home care workers and the client who had failed to implement the regularity principle of the agreement: "even if the home care worker offers to take out [the trash bag], you just say that let us go together" (home care worker). In other words, the worker and the client revitalized or "rewrote" the agreement so as to become a practically effective tool instead of perpetuating a challenging rule This volitional action of joint commitment was grounded in the preceding joint physical action of actually taking out the trash bag together.

In my second case, the client was a 75-year old woman. She felt that her condition was relatively poor, whereas the home care worker saw her condition in more positive terms. The client took care of smaller daily chores but needed help in bigger tasks. The client had a Mobility Agreement, constructed to support the client's volitional actions to maintain and develop her mobility. The visit was focused on the assessment of the implementation of the agreement as well as to further planning and introduction of useful mobility exercises.

> **Home care worker**: Well, right. Now that you have made this
> Mobility Agreement, you have agreed . . . that you will try
> to take care of washing clothes, washing dishes, and cooking
> yourself also in the future. Isn't that so? . . . You didn't agree to
> conduct other exercises besides these everyday chores?
>
> **Clien**t: No.

> **Home care worke**r: Right. So this is based on the idea that we won't wash dishes for you. Is that so?
>
> **Clien**t: Yes.

The home care worker asked the client to test if she could stand up from the chair five times. The client was able to complete the exercise two times. The home care worker then introduced the exercise booklet to the client.

> **Home care worker**: Did you discuss with Sarah [another home care worker] these exercise programs [shows the exercise booklet attached to the Mobility Agreement]?
>
> **Clien**t: No, we did not.
>
> **Home care worke**r: The idea of these is that we try to repeat on a daily basis these exercises, and that way to maintain and improve your mobility. Are you interested in this?
>
> **Clien**t: Yes, I am interested. But I cannot carry out all of them.
>
> **Home care worke**r: Yes, and probably it would not be wise either. And it is by no means a good idea to start doing them alone. But would you be ready to add a few of these [into your Mobility Agreement]? So that when you have a good day and you feel energetic, we will do a few of these to improve your balance and the strength of your arms.

The home care worker and the client proceeded to test physically some of the other exercises. At the end of this, the home care worker asked if the client would like to keep the exercise booklet.

> **Home care worker**: Would you like me to leave this [the exercise booklet] with you?
>
> **Clien**t: Yes.
>
> **Home care worke**r: Well, I leave this with you, so you can study it yourself. But this contains also these [exercises] which ask you to stand and move your feet, don't do them yet at this point because your balance may not hold. These can be taken into your program later, these in which you do not really lean on anything.

In this encounter, the Mobility Agreement was revisited, assessed, amended, and tested in volitional physical actions. The previously constructed written agreement was now extended to include the printed exercise booklet that the client could use at her own convenience. The home care worker made a focused effort at conceptualizing the idea of the Mobility Agreement practice.

> **Home care worker**: And now you of course wonder what this
> is and what is the purpose of all this. The purpose is to try
> and maintain your mobility, perhaps even improve it a bit,
> but above all so that you can live in your own home as long as
> you want, and get by in your own home. Of course we would
> wash your dishes faster, but the point is to maintain the mo-
> bility and control of your own hands.

This case further exemplifies the importance of continuous critique, renego-
tiation, and rewriting of the agreement. Clearly possibilization is not a one-off
event, and the representational artifacts that serve possibilization are not static
or closed. Future is a moving target, not a fixed end point.

The mobility agreement is built on explicit written *commitments* to perform
concrete actions. In the first case, the home care worker and the client revived
the commitment to regularly take out the trash in a collaborative way so that the
client would also take a walk outside the home. In the second case, the worker
and the client committed to expand the client's mobility exercises by studying
the exercise booklet and selecting appropriate exercises to be included in the
Mobility Agreement.

The cases also indicate that writing for possibilization may be best under-
stood as a multimodal achievement. Ed Hutchins (2005) points out that multi-
modal representations are likely to become more robust than single-mode ones.
Multimodal integration may be accomplished by embedding the representations
in durable material media, or "material anchors" (Hutchins, 2005, p. 1555),
such as the trash bag in the first case and the illustrated exercise booklet in the
second case. Another way to accomplish multimodal integration is to enact rep-
resentations in bodily movements, turning such bodily movements into "somat-
ic anchors" for concepts and texts (Hutchins, 2010, p. 445).

FOUR-FIELD MODELS

We conducted an intervention study at a public primary health care center in
Finland in 2004-2005. The center was new, and its chief physician wanted to do
something about the care of difficult patients. He suggested that the staff should
aim at working with "two pipelines," one for common one-problem patients,
the other one for difficult patients, such as those with multiple chronic illnesses,
addictions, multiple medications, mental health problems, etc. Patients put into
the second pipeline should be investigated, conceptualized and new tools for
their care should be developed. My research team began to follow patients iden-
tified by the practitioners as potentially difficult. We interviewed these patients,

observed their consultations, and eventually brought them into so-called laboratory sessions with the staff, to discuss their needs and services. All these interactions were recorded.

One of our initial findings was that the patient and the professional caregiver often saw the situation in radically different light. What was a "heartsink case" for the practitioner may have been a first ray of hope for the patient.

> **General practitioner**: She is a red flag to me, and I'd rather hand her over to someone else, redirect her elsewhere, for example to the psychiatric clinic. But they won't take her because she wants medicine but not therapy. She needs more and gets less; she is the last one I'd like to talk with.

> **Patient**: This personal general practitioner of mine, she really cares for me. This is the first time I get this feeling that she not only renews my prescription but also demands that I come to consultation and says it firmly. Now of course even more firmly, but it does help me!

It became clear to us that the construction of the patient is a two-dimensional achievement. On the one hand, the client or the patient herself may be active or passive in helping herself. On the other hand, the network of professional caregivers may be active or passive in collaborating and coordinating their efforts. With these two dimensions, we put together a four-field diagram in which we could depict the possible movement of the patient. Figure 11.2 depicts this co-constructed movement. The upper arrow represents the movement of the professionals as seen by the patient; the lower arrow represents the movement of the patient as seen by the professionals.

The use of this representation had consequences when patients began to reflect on their life and care with the help of this instrument. Here is an example from such a session with a patient who was initially considered very difficult in that she would cling to the practitioners and become dependent on their constant attention.

> **Family guidance worker**: Well, I'd like to ask if it is useful to meet again in this combination, or shall we continue each one? So that we'll carry on with Vera in the Family Guidance Clinic, and—

> **Patient**: I think probably no. At least now I don't feel that this is necessary. Because *everyone* has now been in a couple of these meetings and knows where we stand. So I can be in touch, tell you if something big and radical happens. And how each one of

you can help if it is close to your profession. This sounds funny, but this is how I think. Or what do you think?

Child welfare supervisor: Your idea sounds good to me, that you don't want to cling to us after all.

Patient: Exactly. Because it helps me forward this way.

Family guidance worker: These are big issues, yes.

Patient: About that model, if you want my comment, it seemed pretty utopian when you started making it. But now that I look at it, it kind of pulls me better into life. I mean, this is how it goes, or how it must go, normally. It's been a long time, about ten years, since I've been working, so I've lost touch with development. I have adapted, accepted things as they are. I haven't realized that there may be something else. I mean, normal work and life and such. So that was a pretty good move. When you see it there in front of us, it makes things concrete. It sticks. It would be good to get a copy.

Researcher: Yeah, I'll take a photo and send it to you by email. And a copy will be delivered home to you [the patient].
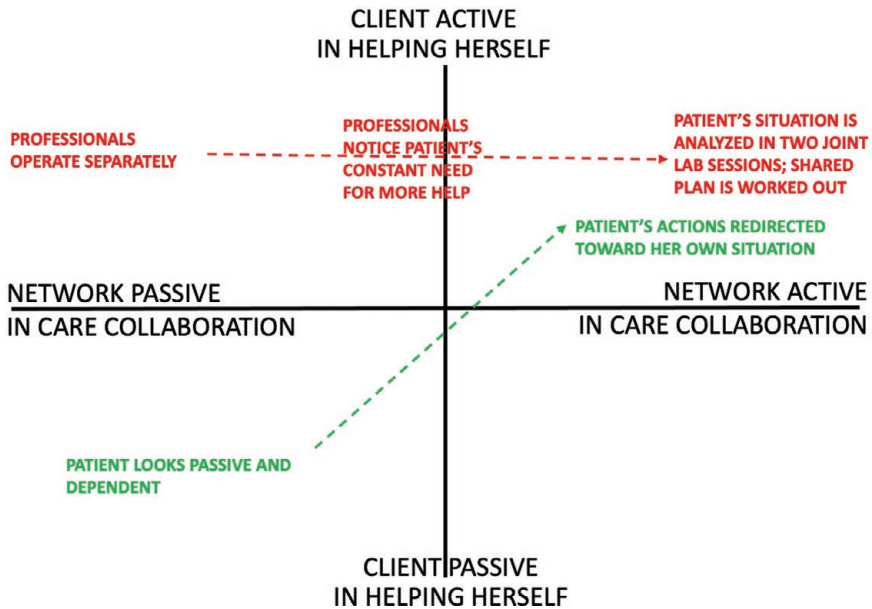

Figure 11.2. Four-field model for depicting the zone of possibilities for the patient and her caregivers (Engeström, 2007, p. 274)

Four-field models have subsequently been used in many formative Change Laboratory (CL) interventions around the world (for the theory and methodology of CL, see Sannino et al., 2016). Sharon Chang's recent work on Chinese and Korean preservice bilingual teachers provides an interesting example (Chang, 2021; see also Chang et al., 2021). In her study, the preservice bilingual teachers had the position of clients as broadly understood in the present analysis, while the instructors of the bilingual teacher education program represented the professionals. In the four-field model co-constructed in Chang's study, the horizontal axis represented a continuum from teacher as assimilator to teachers and students as advocates (in terms of bilingual teacher beliefs and philosophical stance). The vertical axis denoted a continuum from decontextualized learning to contextualized learning (in terms of bilingual curriculum design and pedagogical decisions). The CL participants visualized their growth as both teachers and learners by moving within the four quadrants and using their experience to collectively form new concepts and discover potential solutions together. Chang characterizes the functioning of the four-field model as follows:

> The four-field model allowed the CL participants to express their understandings regarding their experiences in their day-to-day practice and articulate the ways this situated activity was tied to the historical contradictions and structural barriers in bilingual education. The participants then considered how they could respond to their own conflicting motives. In this context, the four-field model provided a visual-spatial heuristic scaffolding tool that allowed the teacher educator to understand the preservice teachers' future-oriented actions. (Chang, 2021, p. 227)

Each student teacher produced an individual four-field model by reflecting on one's experiences of teaching in bilingual classroom placements. Each student-teacher marked their own position in the diagram once a week for six times. This way each student's completed four-field depicted a trajectory of movement and development over time. Each week the marking in the model was complemented by written comments in a four-field model worksheet. These reflections were shared and discussed among the participants:

> The CL participants demonstrated movement in their individually-generated four-field model away from blaming the existing challenges and restrictions and towards creative and active problem solving in bilingual education to better meet the needs of English language learners. Using the individually-generated

four-field model, the CL participants collectively reflected on
how to transform their current circumstances to become cultur-
ally responsive bilingual teachers. (Chang, 2021, p. 233)

Figure 11.3 depicts the completed individual four-field model of one stu-
dent, Joy. The numbers indicate the dates of the weekly markings. Chang points
out that Joy moved back from November 4 to November 18 on the horizontal
X-axis before reaching the upper right-hand quadrant on November 25, focusing
on making bilingual learning more equitable for her English language learners.

Joy herself commented on the zig-zag movement depicted in Figure 11.3 as
follows:

At first, when I saw that I stayed at the same spot after a week
in the field, I was panicking and I thought: "Why didn't I make
any change (or even [went] back) for this week?" and I felt real-
ly bad. But after [the professor] said that it is totally okay to be
back and forth, I got the point. Learning is never a direct path,
and in the way of being a good teacher, it is OK to come across
some rubs. Therefore, the four-field model and trajectory are
like a guidance for me, to make me reflect on myself at a certain
part of time, thinking where I can be better. I think that's the
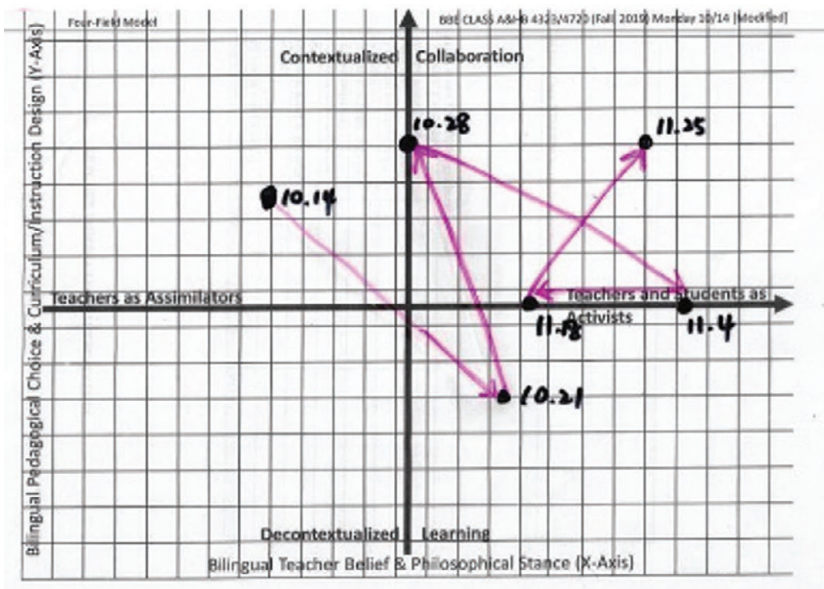meaning of it. (Joy, Four-Field Model Worksheet)

Figure 11.3. Joy's individually generated four-field model (Chang, 2021, p. 239)

The two examples discussed in this section show that four-field models require and serve the purpose of *envisioning* the direction of development needed to break out of a paralyzing conflict of motives (Sannino, 2015). At the same time, these models and the written reflections attached to them allow both clients and professionals to trace the stepwise and typically non-linear progression of opening up a new field of possibilities.

The axes of a four-field model are attempts to capture societally critical dimensions of development in an activity. The stepwise movement depicted in the four-field reflects individual and collaborative efforts to understand the past and design the possible future of an individual client and the practitioners working with her or him. Thus, a four-field model is aimed at bringing together the political and the personal.

PATHWAY REPRESENTATIONS

Pathway representations are prominent in health care. The term "care pathway" or "clinical pathway" is internationally accepted in healthcare management. A clinical pathway is a method for managing the care of a well-defined group of patients during a well-defined period of time. Aimed at increasing efficiency in the use of resources by coordinating the roles and sequencing the actions of the different caregivers, a clinical pathway explicitly states the goals and main steps of care. Deviations from the pathway are documented and evaluated as variances.

As *normative* guidelines care pathways represent a step beyond the *etic* approach to documentation discussed by Berkenkotter and Ravotas (1997). A care pathway tells how the professionals *should proceed* with the patient. Documentation is reserved for deviations to be corrected (Allen, 2009; Martin et al., 2017; Pinder et al., 2005).

In studies of homelessness, the notion of pathway has a different meaning. A homelessness pathway describes a *typical trajectory* into, through and possibly out of homelessness. Anderson and Tulloch defined a homelessness pathway as a description of "the route of an individual or household into homelessness, their experience of homelessness and their route out of homelessness into secure housing" (2000, p. 11).

Classifications of homelessness pathways are meant to be *descriptive,* not normative. As such, they are meant to help practitioners and policy makers to understand varieties of homelessness and to identify priorities for counteracting or reducing homelessness. Table 11.1 summarizes a few examples of classifying homelessness pathways in recent research literature.

Table 11.1. Examples of Categorization of Homelessness Pathways

Kostiainen (2015): THREE PATHWAYS: (1) transitionally homeless people whose pathways lead to stable housing after an episode of homelessness; (2) homeless people with insecure housing careers; (3) disadvantaged homeless people who rely on homeless services
Chamberlain & Johnson (2011): FIVE PATHWAYS: (1) housing crisis; (2) family breakdown; (3) substance abuse; (4) mental health; (5) youth to adult
Fitzpatrick et al. (2013): FIVE PATHWAYS: (1) mainly homeless; (2) homelessness and mental health; (3) homelessness, mental health, and victimization; (4) homelessness and street drinking; (5) homelessness, hard drugs, and high complexity
Sunikka (2016): FOUR PATHWAYS: (1) the pathway to dwelling population; (2) the pathway leading to back and forth movement between homelessness and dwelling; (3) the pathway to homelessness; (4) the pathway to death
Wiesel (2014): FOUR PATHWAYS: (1) hectic private rental pathways; (2) pathways of homelessness; (3) pathways out of homeownership; (4) repeat moves in and out of social housing

As may be seen in Table 11.1, homelessness pathways have been primarily constructed on the basis of statistical or interview data concerning "typical" background factors and critical steps or turning points of homelessness in a given population. This way pathways become categories or taxonomies of different "typical" clusters, profiles or chains of factors that often lead to homelessness. Such categories are inherently *top-down abstractions.* Real individual people seldom if ever match fully a single prototypical pathway. Pathways experienced by real people are heterogenous hybrids. This means that the predominant pathway categories are problematic if used as practitioners' tools for diagnosing, predicting, and planning steps or actions for specific clients. To use the available pathway categories this way, one has to force an individual client to match a predetermined pathway. Elements of this critique have been voiced by some scholars:

> Analyzing homelessness as subgroups or as sets of pathways provides one way to try to tackle this issue, as it breaks homelessness up into more manageable conceptual chunks. However, taxonomies always have some element of compromise; there are "boundary" cases that could go into one category or another, and decisions about the criteria used to identify each subgroup and whether it represents a robust basis for analysis are rarely straightforward . . . Building clear and consistent pathways or subgroups is likely to be difficult in a data-rich environment with a wide definition of homelessness. Recent work from the US has shown how adding new data can disrupt taxonomies that were assumed to be relatively robust. (Pleace, 2016, p. 30)

Frontline work with homelessness—both preventive and rehabilitative—operates with specific individuals. Practitioners need to understand the life courses of homeless people and people at the risk of becoming homeless—as well as the courses of actions taken by service providers and professionals. For this purpose, we need a radically different type of homelessness pathways. They need to be jointly constructed by a practitioner and a client. They need to capture essential steps and features of the particular client's life course and of the courses of action taken by professionals dealing with the client. And they need to be constructed with the help of standard building blocks—a common vocabulary—so that they can be easily compared and critical phases and issues can be identified to enable intervention and transformation of practices.

This challenge was taken up in a CL intervention conducted by the research team of Annalisa Sannino in 2019 in Helsinki. In this CL, 27 homelessness professionals representing Finnish ministries, cities, and NGOs, supported by three researchers, analyzed the state of efforts to eliminate homelessness in the nation and designed an action program named *Housing First 2.0* to move these efforts to the next stage. In one of the sessions of the CL, the participants were asked to read two concise autobiographical accounts of homelessness by Mikko and Tomi, which was recently published in a book of interviews titled *Faces: Stories of Homelessness* (Pyyvaara & Timonen, 2017). The participants were asked to construct homelessness pathways for Mikko and Tomi, using a notational template given by the researchers (Figure 11.4). The participants were asked to analyze what should have been done or needs to be done differently and by whom in these cases.
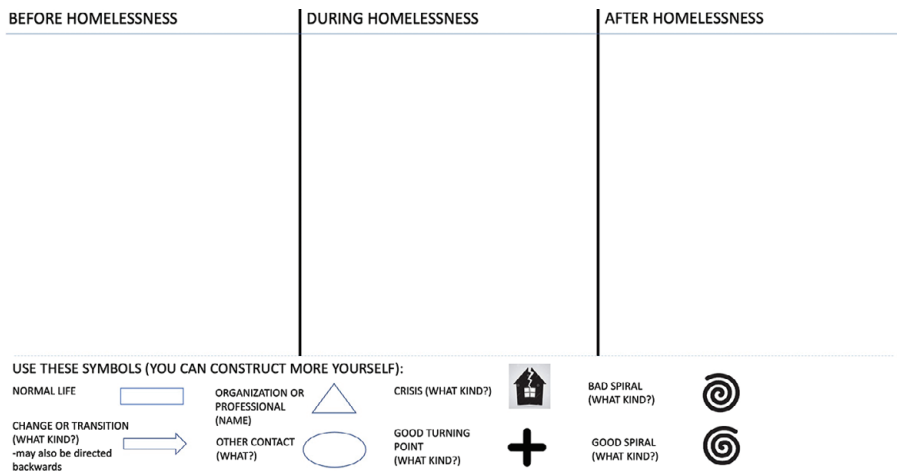

Figure 11.4. Notational template for constructing homelessness pathways for possibilization
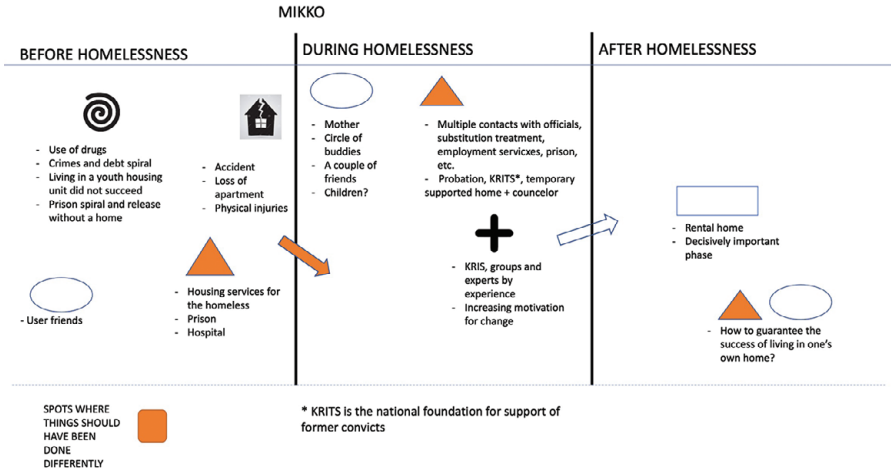
Figure 11.5. A CL participant's representation of Mikko's homelessness pathway
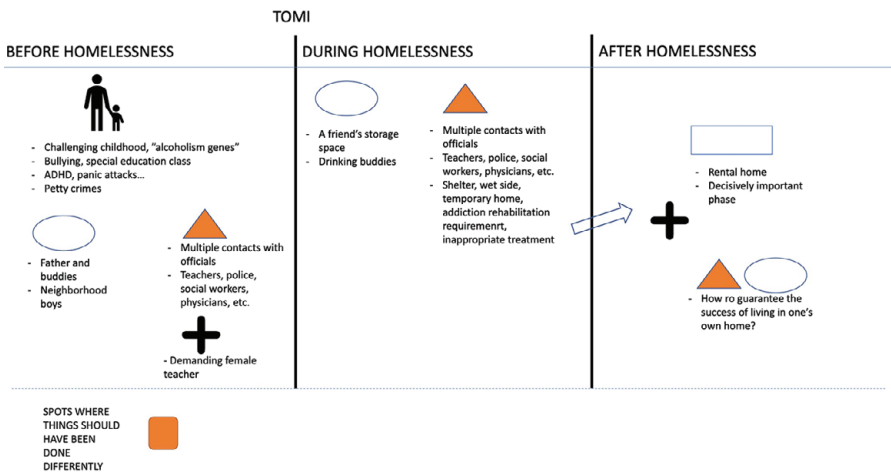

Figure 11.6. A CL participant's representation of Tomi's homelessness pathway

The template moves in time from the situation before homelessness into the situation during homelessness and after homelessness. The idea is to capture and represent a homeless person's trajectory as they experience it, including anticipated future steps and actions. In the next session of the CL, the participants presented and compared their pathway representations. Figures 11.5 and 11.6 depict one participant's pathway representations for Mikko and Tomi.

Overall, the participants found the proposed template and symbols easy to use. Many of them generated additional symbols. In Figure 11.6, the very first symbol was added by the participant. It represents Tomi's childhood and family situation.

One of the participants, a manager of supported housing for formerly home-less clients run by a major NGO, took the assignment to a group of clients. These clients were residents of a supported housing unit, with a background of lengthy periods of homelessness. Working in pairs, members of this group produced their own solutions to the assignment. Figure 11.7 is a photo of one of the resulting representations.

Notable in Figure 11.7 is the detailed elaboration of symbols. The authors of this representation added symbols for the hospital, for the prison, for drugs, for social security benefits, for the adjustment of debts, and for several other components in pathways of Mikko and Tomi, including "memories of a bad adolescence."

The experience gained in the CL indicates that this kind of representation of homelessness pathways is a potentially powerful tool in the service of analysis and *forward-oriented planning* conducted in dialogue and negotiation between a client and a professional. It seems particularly apt to serve as an instrument of *criticism of past failures* or mistakes that can be turned into poignant plans for and commitments to near-future emancipatory actions.
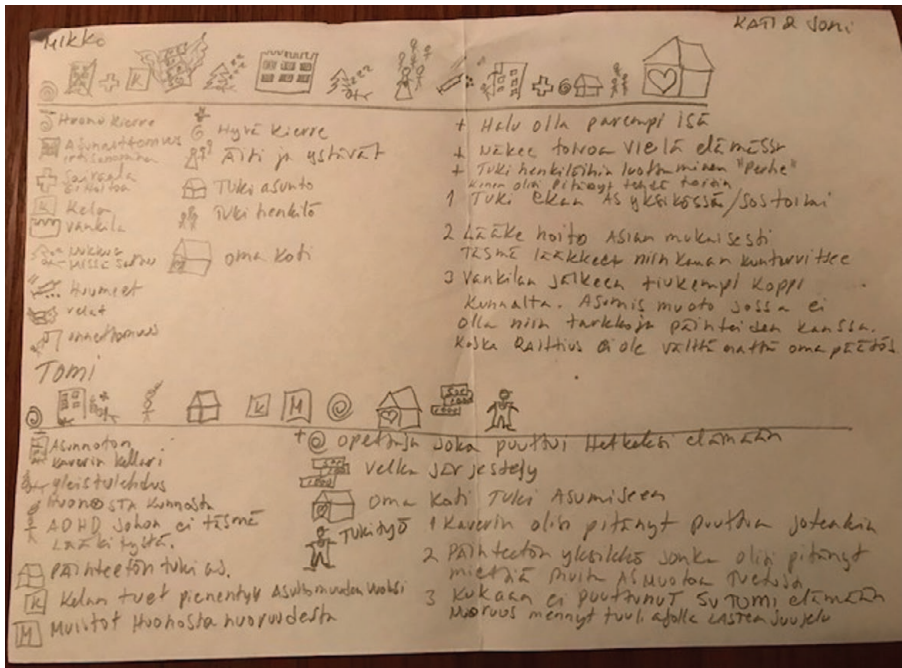

Figure 11. 7. Representation of homelessness pathways produced by a pair of formerly homeless residents of a supported housing unit

The manipulability and malleability of the symbols in the template is an important characteristic of this instrument of possibilization. Writing is here intimately intertwined with pictorial representation and the possibility of playing with alternative material symbols and their positions. The pathway representation affords a degree of *decontextualization* in the sense of representing uniquely personal experiences with the help of general symbols, and *recontextualization* in the sense of building a tailor-made trajectory that is meaningful and challenging for both the client and for the system of services. The idea of this kind of a pathway representation echoes an observation made by Bazerman a few years ago: "models are for users rather than analysts and are invoked situationally and mutably" (2018, p. 301).

CONCLUSION: TOWARD A POLITICS OF DELIBERATIVE REPRESENTATIONAL SHIFTS

The idea of possibilization advocated here is based on Vygotsky's dialectical insight into human empowerment:

> The person, using the power of things or stimuli, controls his own behavior through them, grouping them, putting them together, sorting them. In other words, the great uniqueness of the will consists of man having no power over his own behavior other than the power that things have over his behavior. But man subjects to himself the power of things over behavior, makes them serve his own purposes and controls that power as he wants. He changes the environment with the external activity and in this way affects his own behavior, subjecting it to his own authority. (1997, p. 212)

We may now return to the initial distinction Berkenkotter and Ravotas (1997) made between *emic* and *etic* representation, summarized in Figure 11.1. In Figure 11.8, this summary is extended to include jointly constructed dynamic texts and models that serve possibilization.

	CLIENT'S *EMIC* ORAL ACCOUNT	PROFESSIONAL'S *ETIC* WRITTEN ACCOUNT	JOINTLY CONSTRUCTED *DYNAMIC* TEXT AND MODEL
LINGUISTIC PREFERENCE	ACTIVE VERBS	NOMINALIZATIONS, INCLUDING NUMERALLY BASED CATEGORIZATIONS	COMMISSIVES, PROJECTIONS AND TRAJECTORIES
PURPOSE AND FUNCTION	EXPRESSION OF CONCERN	STABILIZATION	POSSIBILIZATION
GENERAL QUALITY	CONTEXTUALIZED, EMIC	DECONTEXTUALIZED, ETIC	RECONTEXTUALIZED, PROSPECTIVE

Figure 11.8. Three forms of representation in professional-client interactions

Figure 11.8 implies the possibility of developing a politics of representation that does not stop with *etic* records but makes deliberate shifts to possibilization. Such a politics of representational shifts can only be accomplished in a deliberative way, understood as "involving careful thought and discussion when making decision" (*The Cambridge English Dictionary*).

It is unlikely that the shifts can be made in a linear fashion. Figure 11.9 depicts the shifts between the three kinds of representation in the case of the Mobility Agreement for home care clients, discussed earlier. In this case, the possibilization instrument is invoked as the second step, after the client's oral *emic* account. The *etic* record is commonly generated partly on the basis of the Mobility Agreement, as the third step. Most importantly, the practical implementation of the agreement involves renegotiation and often significant extension of the agreement, giving the process an iterative and cyclic pattern.
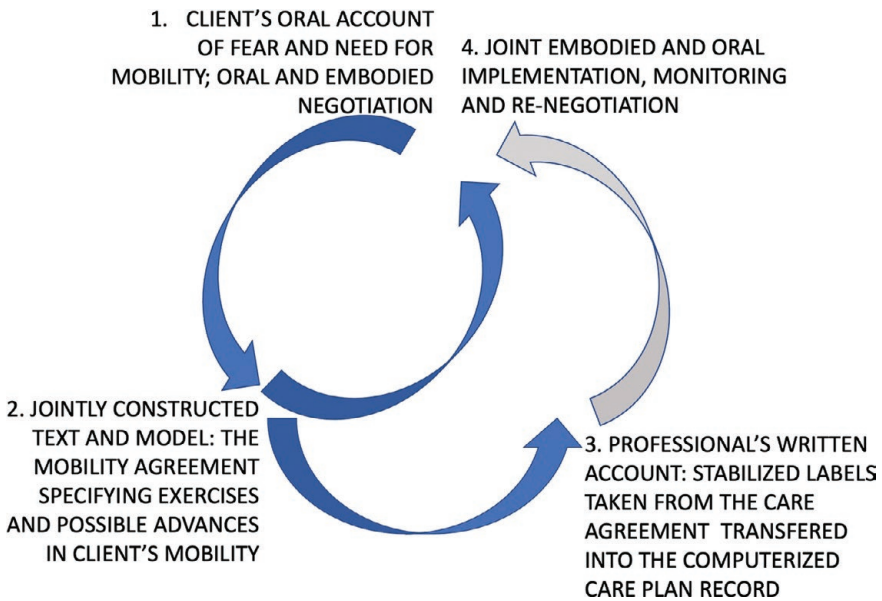
1. CLIENT'S ORAL ACCOUNT OF FEAR AND NEED FOR MOBILITY; ORAL AND EMBODIED NEGOTIATION

4. JOINT EMBODIED AND ORAL IMPLEMENTATION, MONITORING AND RE-NEGOTIATION

2. JOINTLY CONSTRUCTED TEXT AND MODEL: THE MOBILITY AGREEMENT SPECIFYING EXERCISES AND POSSIBLE ADVANCES IN CLIENT'S MOBILITY

3. PROFESSIONAL'S WRITTEN ACCOUNT: STABILIZED LABELS TAKEN FROM THE CARE AGREEMENT TRANSFERED INTO THE COMPUTERIZED CARE PLAN RECORD

Figure 11.9. The iterative pattern of politics of representation in the case of the Mobility Agreement

Studies and practical projects of participatory and deliberative democracy (Elstub, 2018; Lafont, 2019) usually focus on relatively large collective forms of shaping policies and making decisions, participatory budgeting being a good example (Meléndez, 2021). While extremely valuable, these projects often remain exceptional deviations from life as usual. On the other hand, encounters between relatively powerless lay clients and relatively powerful professionals, often representing governmental and legal apparatuses, are very common in life

as usual. When professionals start building practices of possibilization with individual clients, they will generate important groundwork and the impetus of learning for transformative agency. Such initially individual or dyadic forms of seeing and enacting possibilities can eventually translate into increasingly powerful collective initiatives toward participatory and deliberative democracy.

REFERENCES

Allen, D. (2014). Lost in translation? 'Evidence'and the articulation of institutional logics in integrated care pathways: From positive to negative boundary object? *Sociology of Health & Illness, 36*(6), 807-822.

Anderson, I., & Tulloch, D. (2000). *Pathways through homelessness: A review of the research evidence*. Scottish Homes

Bazerman, C. (1997). Discursively structured activities. *Mind, Culture, and Activity, 4*(4), 296-308.

Bazerman, C. (2018). What does a model model? And for whom? *Educational Psychologist, 53*(4), 301-318.

Berkenkotter, C., & Ravotas, D. (1997). Genre as tool in the transmission of practice over time and across professional boundaries. *Mind, Culture, and Activity*, *4*(4), 256-274.

Chamberlain, C., & Johnson, G. (2011). Pathways into adult homelessness. *Journal of Sociology*, *49*(1), 60-77.

Chang, S. (2021). Supporting expansive learning in preservice bilingual teachers' zone of proximal development of the activity system: An analysis of a four-field model trajectory. *Professional Development in Education*. https://doi.org/10.1080/19415257.2021.1879232

Chang, S., Martínez-Roldán, C. M., & Torres-Guzmán, M. E. (2021). The manifestation of Chinese preservice bilingual teachers' relational agency in a Change Laboratory intervention. *Mind, Culture, and Activity*. https://doi.org/10.10 80/10749039.2021.1881125

Elstub, S. (2018). Deliberative and participatory democracy. In A. Bächtiger, J. S., Dryzek, J. Mansbridge, & M. E. Warren (Eds.), *The Oxford handbook of deliberative democracy* (pp. 187-202). Oxford University Press.

Engeström, Y. (1996). Development as breaking away and opening up: A challenge to Vygotsky and Piaget. *Swiss Journal of Psychology*, 55, 126-132.

Engeström, Y. (2007). From stabilization knowledge to possibility knowledge in organizational learning. *Management Learning*, *38*(3), 271-275.

Engeström, Y., Kajamaa, A., & Nummijoki, J. (2015). Double stimulation in everyday work: Critical encounters between home care workers and their elderly clients. *Learning, Culture and Social Interaction*, 4, 48-61.

Engeström, Y., Nummijoki, J., & Sannino, A. (2012). Embodied germ cell at work: Building an expansive concept of physical mobility in home care. *Mind, Culture, and Activity*, *19*(3), 287-309.

Epstein, M. (2019). *A philosophy of the possible: Modalities in thought and culture*. Brill.

Fitzpatrick, S., Bramley, G., & Johnsen, S. (2013). Pathways into multiple exclusion homelessness in seven UK cities. *Urban Studies*, *50*(1), 148-168.

Grimes, M. G., & Vogus, T. J. (2021). Inconceivable! Possibilistic thinking and the sociocognitive underpinnings of entrepreneurial responses to grand challenges. *Organization Theory*, *2*(2).

Hutchins, E. (2005). Material anchors for conceptual blends. *Journal of Pragmatics*, *37*(10), 1555-1577.

Hutchins, E. (2010). Enaction, imagination, and insight. In J. Stewart, O. Gapenne, & E. A. Di Paolo (Eds.), *Enaction: Toward a new paradigm for cognitive science* (pp. 425-450). MIT Press.

Kostiainen, E. (2015). Pathways through homelessness in Helsinki. *European Journal of Homelessness*, *9*(2), 63-86.

Kramer, M. (2018). Promoting teachers' agency: Reflective practice as transformative disposition. *Reflective Practice*, *19*(2), 211-224.

Kumpulainen, K., Kajamaa, A., & Rajala, A. (2018). Understanding educational change: Agency-structure dynamics in a novel design and making environment. *Digital Education Review*, (33), 26-38.

Lafont, C. (2019). *Democracy without shortcuts: A participatory conception of deliberative democracy*. Oxford University Press.

Martin, G. P., Kocman, D., Stephens, T., Peden, C. J., & Pearse, R. M. (2017). Pathways to professionalism? Quality improvement, care pathways, and the interplay of standardisation and clinical autonomy. *Sociology of Health & Illness*, *39*(8), 1314-1329.

Mehan, H. (1993). Beneath the skin and between the ears: A case study in the politics of representation. In S. Chaiklin, & J. Lave (Eds.), *Understanding practice: Perspectives on activity and context* (pp. 241-268). Cambridge University Press.

Meléndez, J. W. (2021). Latino immigrants in civil society: Addressing the double-bind of participation for expansive learning in participatory budgeting. *Journal of the Learning Sciences*, *30*(1), 76-102.

Mizrahi, T. (1985). Getting rid of patients: Contradictions in the socialization of internists to the doctor-patient relationship. *Sociology of Health & Illness*, *7*(2), 214-235.

Moscrop, A. (2011). 'Heartsink' patients in general practice: A defining paper, its impact, and psychodynamic potential. *British Journal of General Practice*, *61*(586), 346-348.

Nummijoki, J., & Engeström, Y. (2009). Towards co-configuration in home care of the elderly: Cultivating agency by designing and implementing the mobility agreement. In H. Daniels, A. Edwards, Y. Engeström, T. Gallagher, & S. R. Ludvigsen (Eds.), *Activity theory in practice: Promoting learning across boundaries and agencies* (pp. 49-71). Routledge.

Nummijoki, J., Engeström, Y., & Sannino, A. (2018). Defensive and expansive cycles of learning: A study of home care encounters. *Journal of the Learning Sciences*, *27*(2), 224-264.

O'Dowd, T. C. (1988). Five years of heartsink patients in general practice. *British Medical Journal*, *297*(6647), 528-530.

Pike, K. (1954). *Language in relation to a unified theory of the structure of human behavior*. Summer Institute of Linguistics.

Pinder, R., Petchey, R., Shaw, S., & Carter, Y. (2005). What's in a care pathway? Towards a cultural cartography of the new NHS. *Sociology of Health & Illness*, *27*(6), 759-779.

Pleace, N. (2016). Researching homelessness in Europe: Theoretical perspectives. *European Journal of Homelessness*, *10*(3), 19-44.

Pyyvaara, U., & Timonen, A. (2017). *Naamat: Tarinoita asunnottomuudesta*. Into Kustannus.

Rainio, A. P., & Hofmann, R. (2021). Teacher professional dialogues during a school intervention: From stabilization to possibility discourse through reflexive noticing. *Journal of the Learning Sciences, 30(4-5), 707-746.*

Sannino, A. (2015). The principle of double stimulation: A path to volitional action. *Learning, Culture and Social Interaction*, 6, 1-15.

Sannino, A. (2022). Transformative agency as warping: How collectives accomplish change amidst uncertainty. *Pedagogy, Culture & Society, 30*(1), 9-33.

Sannino, A., & Engeström, Y. (2018). Cultural-historical activity theory: Founding insights and new challenges. *Cultural-Historical Psychology, 14*(3), 43-56.

Sannino, A., Engeström, Y., & Lemos, M. (2016). Formative interventions for expansive learning and transformative agency. *Journal of the Learning Sciences*, *25*(4), 599-633.

Smith, B. C. (1996). *On the origin of objects*. The MIT Press.

Sunikka, S. (2016). *Hietsussa yöpyneiden asunnottomuuspolut: Liikkuvuus asunnottomuuden ja asuntoväestön välillä*. Licentiate thesis. University of Helsinki, Faculty of Social Sciences.

Thuneberg, H., Hautamäki, J., Ahtiainen, R., Lintuvuori, M., Vainikainen, M. P., & Hilasvuori, T. (2014). Conceptual change in adopting the nationwide special education strategy in Finland. *Journal of Educational Change*, *15*(1), 37-56.

Vygotsky, L. S. (1997). The history of development of higher mental functions, Chapter 12: Self-control. In R. W. Rieber (Ed.), *The collected works of L.S. Vygotsky: The history of the development of higher mental functions*, *4* (pp. 207-219). Plenum.

Wiesel, I. (2014). Mobilities of disadvantage: The housing pathways of low-income Australians. *Urban Studies*, *51*(2), 319-334.

Yasukawa, K., Brown, T., & Black, S. (2014). Disturbing practices: Training workers to be lean. *Journal of Workplace Learning*, *26*(67), 392-405.