2

The second phase – mid-1970s to mid-1980s

Cultural landscape

The second phase can be seen to reveal some important movements in the family therapy field away from the pragmatic and somewhat behaviourist emphasis of the first phase towards a rationalist philosophical approach more central to European traditions of thought. In particular, the ideas of Kant, who stressed that our knowledge of the world was inevitably a construction and questioned the notion of objective reality, inspired the growth of humanistic psychologies in the USA. There were also the wider cultural movements towards individualism, personal growth, inner exploration, creativity and individuality, for example as seen in alternative movements, such as the hippies, ecology groups, gay rights movements and anti-racist movements. In psychotherapy constructivist ideas had a profound effect, for example the work of George Kelly (very much inspired by Kant's ideas) and Carl Rogers, which led to person-centred forms of therapy and counselling. These took as a central aim the establishing of empathy by attempting to understand the client's world from his or her perspective, rather than that of an expert therapist. More generally, there was a movement in psychology away from behaviourism and ***positivism*** towards cognitive approaches that focused on how people actively attempted to form versions of the world which shaped their actions. Earlier, Bateson had also been influenced by humanistic and existential ideas and linked his idea of epistemologies, for example, with George Kelly's notion of construct systems (a personal but organized set of interconnected constructs or beliefs).

Outside the USA one of the most significant developments was that of the Milan team in the 1970s. Palazzoli et al. (1978) turned to Bateson's ideas, especially his emphasis on families as centrally concerned with the formation of shared meanings or 'epistemologies' through multilayered communicational processes. Possibly Bateson's interest in ecology, cultural and spiritual beliefs also connected with the importance of religious life in Italy. More generally, Italy has also been identified with a strong emphasis on the family through Catholicism and with a dedication to family ties and honour.

An important factor may also have been the contemporary development of the

Key people, places and events (bird's-eye view)

The shift to second-order cybernetics heralds an important change in the beliefs about the role of the therapist. The zeal for helping families to change inevitably led to experiences of so-called 'resistance' in families, which in turn led to questions about both the nature of change (**Dell** 1982; **Keeney** 1983; **de Shazer** 1982) and debates about first- and second-order change (**Watzlawick** et al. 1974). An awareness developed that grasping the 'emotional logic' in each distressed family situation was crucial if family 'rules' were to alter and transformational change to occur. The use of the 'positive connotation' demonstrated in the work of the **Milan Associates** led to Milan systemic therapy, as it came to be called in the early 1980s, being associated with the therapist's quest for an understanding of a family belief system as a fundamental part of the process of change. Their exploration also supported the work of **Maturana** and **Varela** (1980) and the constructivist position that challenged the assumption that the therapist could be an objective observer outside a family system. Instead, as the therapist became involved with a family system, he or she became part of that system.

By the mid-1980s there were two strands to therapists' beliefs about therapy: those who believed change was instrumental and that intentionality on the part of the therapist was bound to work; and those who were more cautious and could take a position of uncertainty and question the effect of their presence on the family system and were profoundly influenced by **Bateson**'s (1972) emphasis on meaning and pattern. Brief therapy (de Shazer 1982) has emerged, alongside the work of the Mental Research Institute (MRI) of Palo Alto, as an approach that appeals to many therapists. Alongside and inextricably linked was the emergence in this phase of postmodernism as the dominant view of the world. The fit between a constructivist view and the questioning of postmodernism is obvious.

This second phase takes us from the development of the team and use of the one-way screen with predominantly first-order modernist ideas to the beginnings of a questioning in the mid-1980s of the implications for family members of unseen therapy teams sending expert messages to family members.

work of the psychiatrist Basaglia. He promoted a radical revision of psychiatric services in Trieste and other areas which was inspired by Marxist and humanistic perspectives. For example, a radical community-based provision of services for patients and their families was developed which challenged the medical orthodoxy of treatments through medication and confinement. Likewise the Milan team's non-pathologizing and liberating views of problems and families were a challenge to psychiatric orthodoxy. Developments were also occurring in Canada in the work of Karl Tomm and elsewhere, for example, the UK and Germany.

In Britain there were a number of interesting developments. The writings of R.D. Laing in the early 1970s promoted a critique of traditional psychiatry and also drew upon Bateson's ideas, such as the double-bind theory, which were developed to describe the processes of the construction and destruction of children's experiences and identities in families. Laing drifted away from the emerging family therapy

movement in the UK which he saw as lacking political sensitivity. He also saw the movement as overconcerned with manipulating and 'fixing' families without fundamentally questioning some of the abuses that families inevitably perpetuated from their internalizations of the materialist values of external society.

An imaginative approach linking personal construct theory to systemic ideas was also developed by Harry Procter (1981, 1985). In the early 1980s the Milan approach had a major impact on family therapy in Britain. However, the family movement in Britain remained relatively eclectic, with many practitioners continuing to be influenced by earlier strategic and structural ideas and also by psychoanalytic traditions, especially Bowlby's important ideas regarding the importance of early attachments in families.

Influential people and ideas

> Mental illnesses are indeed mental, in that they are at least 90 per cent made up of blame, or causal attributions that are felt as blame.
>
> We do not 'discover' the world-out-there but, on the contrary, 'invent' it.
>
> (Hoffman 1993: 391, 390)

Second-order cybernetics

A popular view of the shift from first- to second-order cybernetics is that it represents a radical departure and resulted from a number of important critical reappraisals of systems theory (Dell 1982; Keeney 1983). An alternative story is that the shift occurred gradually over a period of time and that the basic principles, notably an emphasis on the construction of meanings, were evident in early writings but were subjugated in the enthusiasm to apply, in an instrumental way, systemic ideas to help distressed people and their families.

The shift to second-order cybernetics has been seen as centred on a critique of the first applications of systems theory, which were seen as offering an overly mechanistic view of families as composed of people actively co-creating meanings. Though the observation of behaviour patterns was still seen as an important starting point, the emphasis moved to an exploration of the meanings, beliefs, explanations and stories held by family members. Inherent in the shift to second-order cybernetics was an important shift in the perceived role of the therapist. In first-order cybernetics the therapist was largely seen as an 'expert' – a scientist who was seen to be able to accurately diagnose the problems in the family, identify the functions that symptoms were serving and intervene to alter these so that the unhealthy function that the symptoms were serving could be remedied. In contrast, in second-order cybernetics the role of the therapist is less of an expert and more of a collaborative explorer who works alongside a family to co-create some new and hopefully more productive ways of the family seeing their situation. Furthermore, this represented a move towards an increased sensitivity to therapeutic relationships. Rather than trying to adopt an 'objective' stance, the therapist is encouraged to be continually reflective – to monitor his or her perceptions, beliefs, expectations, needs and feelings, especially in terms of how these may in turn have an influence on the family.

In effect, early writing (Bateson et al. 1956; Watzlawick et al. 1967) stressed that what we hear in any given communication is in part determined by what we expect and want to hear and by the history of the relationship (context). Likewise, some extreme critiques and rejections of systems theory (Anderson and Goolishian 1988a) can also be seen to be based on a distorted, oversimplified and mechanistic vision of systems theory. This can make for neat and tidy arguments but may not do justice to or represent the depth and complexity of the original ideas.

First-order cybernetics largely adopted a functionalist view of problems: families were seen as interacting systems in which symptoms functioned to preserve stability. Perversely, painful and distressing symptoms, rather than threatening family life and stability, were often seen as holding families together. In effect, symptoms were seen as distracting from or diverting conflicts, anxieties and fears (often unconsciously held) from other areas of the family's experience. Second-order cybernetics challenged this view, predominantly on the grounds that such a functional view was merely an inference in the mind of the observer. The function of a symptom was not there to be discovered, and in fact different therapists often formulated dramatically different functional explanations.

There was a shift away from pathologizing notions of the family to viewing family life as *inevitably* posing difficulties which might or might not lead to distress for some families, depending on how those difficulties were handled. In turn how difficulties were handled – the attempted solutions – was seen as linked to the wider ecology of the family. In particular, families were seen as presented with various developmental hurdles or transitions, such as children leaving home, which needed to be negotiated.

Meta-communication

Watzlawick et al. (1974) proposed that confusions in our thinking could occur because meanings are hierarchically structured. One aspect of this is that not only can we communicate but also communicate about our communication. For example, if a friend says, 'Yes, I like this', and I reply, 'Oh, do you? But you don't sound very sure', I am communicating about communicating and my communication in effect alters or gives another meaning to what they were saying. There are various ways that we can engage in such communication; for example, I may communicate displeasure non-verbally but verbally say, 'Oh, yes I do like it'. Table 2.1 shows some examples of how there can be contradictions between various verbal and non-verbal combinations in our communications.

Table 2.1 Varieties of contradictory levels of communications

	Verbal	*Non-verbal*
Verbal	'Don't listen to me' 'I'm a liar, so don't believe me'	'Yes, I like it' Posture showing displeasure
Non-verbal	Sad body posture 'No, I feel fine . . .'	Stroking in a heavy aggressive manner

Watzlawick et al. (1967) described many examples of paradoxes that could occur within language itself, some evident from earliest writings:

All Cretans are liars. (Epimedes the Cretan)
IGNORE THIS SIGN
'Oh, all right just ignore me.'

In all these examples, to follow the instruction of the message means to break the injunction. So, if someone says 'ignore me', in order to ignore them I first have to attend to their message which means I have failed to ignore them. But if I do not attend to their message I do not ignore them. These paradoxes can be fun but they are also serious in that they may be found in creative and humorous communication, but arguably also play a more pernicious role in pathology.

The verbal part of a message can at times be relatively ambiguous without the non-verbal component to clarify intention. When there is ambiguity or incongruence between the verbal and non-verbal components an attempt at clarification or meta-communication (communication about communication) may be attempted; for example, a mother might say to her child, 'You don't seem very enthusiastic' or 'You seem a bit fed up'. Young children, lacking the verbal ability and power to engage in such clarification, may therefore become confused and disoriented in times of emotional upheavals in a family.

Communication

Communication is simultaneously an act and a message. Put even more simply, speaking, for example, is not only a comment or a description but an action in itself – our communications can make things happen. For example, if I say, 'All generalizations are nonsense', my act of saying this is in itself a generalization and therefore invalidates itself. More generally, we have the capacity to engage in ever higher schemes of reflections – I can act, think about my action, think about my thinking about my action and so on. This is not merely a philosophical diversion, since in relationships these processes can be seen to be very problematic. When one partner says, 'Oh, don't hassle me, you're always doing that', this communication contains a classification of the action, it labels it in a particular way – 'hassling' – and contains a general statement about the place of this in the relationship over time. The receiver of the message therefore has a complex task in responding, for example whether to dispute the classification of the act, or the generalization of how often it occurs, or both, or to treat and respond to the communication itself as an act of criticism, aggression or attack. Whether it is treated as an attack is further indicated by the non-verbal features, the voice tone, posture and so on and also the history or context of the relationship. This may be the immediate history, whether they have been in conflict or kidding, and the long-term history, what kind of a relationship they think they have. In addition, other contextual factors, such as where they are – before an important examination, in a supermarket, at an airport, in bed – may also influence how the communication is interpreted.

For communication to occur there must be both a sender and a receiver. Just how a message is interpreted depends not only on the disposition of the sender or th receiver, but on the interchange between them. The meaning of the communicatio is seen as arising from a process of negotiation involving a further exchange o meta-communication.

The process of communication requires the development of meta-perspective (Laing 1966; Watzlawick et al. 1974; Hoffman 1993) or ideas about how each perso sees the others, their motives, intentions and how they see their relationships with eac other. Through discussions, comments and disclosures the people in a relationshi may form a set of shared beliefs, assumptions, explanations and concerns which i turn come to regulate their interactions, produce predictable patterns of actions an also patterns of emotional responses and thoughts. However, the development c such coordinations of action and meanings is seen to be inevitably prone to problem of misunderstandings, confusions and contests over meaning. Partners may hol competing explanations and stories about the meaning of what is going on betwee them or what should be going on. Problems and difficulties in families are therefor seen as inevitable 'struggles over meaning' (Haley 1963, 1976a; Watzlawick et a 1967, 1974). Meanings, like actions, can be seen as interactional and potentially a escalating; for example, an interaction that involves a negative frame of 'blaming' ca be seen to escalate to a dangerous degree so that a more positive frame is introduce to protect the group from collapsing into bitter dispute. In second-order cybernetic problems therefore are seen not simply in terms of patterns of actions but as th patterns of attempts to give meanings to actions.

Though communication is a central feature of systems theory, the somewha mechanistic models that characterized first-order cybernetics regarded communica tion as the flow of information as in engineering systems, rather than as the creatio and exchange of meanings. Increasingly it became recognized that human communi cation was complex and involved potentially multiple interpretations of any give communication. People in families did not simply act on the basis of feedback bu reflected on the meanings of each other's communications. Specifically, first-orde cybernetics played down the importance of language.

One of the earliest and most significant attempts to consider how the process o mutual construction of meanings in communication occurs was the concept of punc tuation in communicational exchanges. Watzlawick et al. (1967) suggested that th flow of communication and action in relationships is divided up into meaningful unit or chunks. The term 'punctuation' was coined to describe how people develop a set o *self-fulfilling* perceptions or beliefs about their relationship which can interlock, like th pieces of a jigsaw puzzle, to produce repetitive patterns (Figure 2.1). The concept o punctuation introduces the idea of systems as not simply mechanistic, but as governe by patterns of beliefs or constructs. Over time members of a family come to form predictions, not only of each other's actions, but also of each other's thoughts, belief and feelings. Since they spend considerable time together, share similar experience and communicate continually with each other, they come to form a web of mutual anticipation. This serves not only to explain and predict each other's behaviour and thoughts, but also to construct and maintain them. Members of a family might be surprised if, for example, one of them expresses beliefs or shows emotions that they regard as unusual; these signs of surprise will serve to attenuate such deviations.

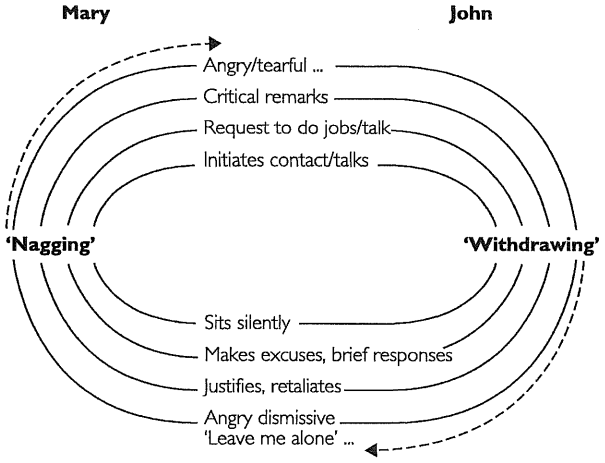

Figure 2.1 Punctuation

In second-order cybernetics personal choice becomes a central issue. Family life is seen to proceed on the basis of each person's beliefs or punctuations of events. However, a picture of individual members of families simply acting on the basis of their personal beliefs and intentions loses the important ideas of patterning and predictability that have been a feature of systemic thinking. A significant contribution to what can become a sterile debate about choice and freedom was the concept of punctuation, which suggests that though two or more members of a family may appear to be acting autonomously, their choices can become interwoven such that in fact they become caught in repetitive patterns of action. A relatively unexplored idea that follows from this is that choice in families can be seen to be *contingent*; what each person decides to do is shaped and constrained by what the others do and by what we think they will do. Specifically, each member may be involved in making conscious or semi-conscious calculations about the likely consequences of a possible line of action – whether it will produce a rebuke, admiration, agreement, and so on. We will develop this idea of shared action in the next section.

The person as private 'biosphere'

The cognitive biologists Humberto Maturana and Francisco Varela (Maturana 1978; Maturana and Varela 1980) developed the more extreme versions of constructivism which have characterized second-order cybernetics – namely, that individuals and systems can only act or respond on the basis of their internal cognitive structure, their personal map of the world. They termed this 'structural determinism'. Likewise, Kelly (1955) and Bateson et al. (1956) had also suggested that each person possesses a unique epistemology, a way of making sense of or explaining the world. Maturana and Varela had in a sense suggested that people are largely informationally closed,

that much if not most of the information and meanings available do not reach us in interactions because we are largely filtering material out according to our expectations.

Intention

The widely quoted phrase 'it is impossible not to communicate' emerged from the systems theory view of communication (Watzlawick et al. 1967: 193). However, this sidesteps the important questions of intention, misunderstanding and unconscious communication. The frequent experience of communication is that we are trying to get a particular message across. We are probably all aware that sometimes we fail in our intention to communicate or that we 'give off' some message, such as lack of confidence, which we do not wish to, but nevertheless that we have some agreement of control over our communications.

It is perhaps possible that intentions may be attributed to us, for example when someone is intent on picking a fight by saying, 'What are you looking at?' A paranoid and aggressive expectation can conclude that a provocative message was being sent. To attribute some communication on the part of the 'victim' in this situation is tantamount to ascribing some blame to them, which is not too dissimilar to ascribing blame to any victim, essentially for being there. Perhaps Watzlawick's axiom should be redefined slightly as 'it is difficult to engage in action or non-action which cannot potentially be interpreted as a communication'.

Beliefs and actions in triads

Second-order cybernetics offered a different view of some of the processes described in first-order cybernetics. For example, the concept of *conflict-detouring* or *triangulation* (Minuchin 1974; Haley 1976a) can be seen in terms of a movement between actions and meanings, and also in terms of a construction of individual experience.

The development of conflict detouring was seen to involve a form of learning by trial and error. A young child might experience the stress and tension between their parents and respond to the raised voices, banging of doors or violence by crying, losing their concentration on what they are doing and getting hurt, feeling sick and so on (Figure 2.2). One or other of these behaviours may be enough to capture the parents' attention and distract them from their struggle to focus on the child. This temporarily produces a cessation of conflict between parents; following several repetitions of this process, the child's behaviour or symptoms can become programmed into the family dynamics and function to maintain the situation. This basic pattern

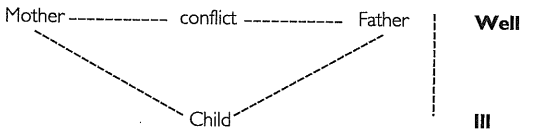

Figure 2.2 Triangulation: parental conflict detouring through a child

can be constructed in a variety of ways and circumstances. The parents may not be in conflict with each other but may be stressed, tired or depressed due to pressures at work or from unemployment. The conflict can cut across generations, for example, between a single mother and her mother or in-laws, between the parents and the child's school and so on. The child's symptoms can in a sense be seen as benevolent, for example, offering a distraction for stressed parents from their own worries.

Triangulation also involves the construction of an agreement about the situation in a family. There is likely to be an agreement that the child is the main cause of the family's current concerns and difficulties. The construction of such an explanation is an example of a family 'myth' (Ferreira 1963; Pollner and Wikler 1985). This is in effect a falsification or distortion of reality since the child's problems can be seen as resulting from, not as causing, the conflict.

The belief that the child is the source of the family's problems has resonances with psychoanalytic concepts in that the distortion can be seen to serve as an emotional defence. Once established, this myth can become increasingly painful to confront. For example, if the child's symptoms become severe the parents may feel extremely guilty and to blame by the implication that their conflicts have in a sense been the cause. However, this picture tends to minimize the child's role as merely responding to the conflicts. In reality, most young children at some stage discover the power that a symptom of illness confers, such as being able to avoid school or unpleasant duties, gain sympathy and attention, and so on. Therefore a child may start to collude with this state of affairs and continue to display symptoms in part because of the apparent advantages he or she gains. This in turn can serve to confirm for the whole family (including the child) the belief or myth that he or she is the source of the problems.

There may be a variety of constructs to describe the child's problems but the net effect of these is that the parents are described as similar to each other, and different from the child, in not having or being the cause of the 'problem'. In reality, the situation is often more complex than this. The parents may disagree on how to treat the child (for example, discipline or sympathy) and may shift positions, taking turns to side with the child. These shifting coalitions can be extremely confusing for a young child and have been implicated in causing or aggravating more severe problems, such as anorexia and schizophrenia (Palazzoli et al. 1978). Psychiatric and other agencies may also perpetuate conflicting views about such conditions, which families then come to internalize and act out in their internal dynamics.

Ecological perspective – multiple systems

Though it was a fundamental axiom of systems theory that any given system should always be seen as interlinked with others, this became a more central feature of second-order cybernetics. It became recognized that the very process of therapy involved an interaction between two systems – the family and the therapist. Over time these could be seen as a new third system – the therapist–family system. Rather than thinking that we could observe and analyse families in any detached and objective manner, it became increasingly clear that the therapist/observer inevitably perturbed or changed the family system by the very act of observing it. A therapist in effect came

to be seen as partly seeing his or her own reflections or the ripples they had made in the new therapist–family system. Another therapist with the same family might see quite different things partly because they were having a different kind of effect on the family. Taken to its extreme, this suggested that there was no such thing as the real family dynamics, only our various perceptions of it.

Observing systems

The emphasis on subjective meanings in terms of the perceptions and punctuations of family members came to be encapsulated in the idea of observing systems. Not only was punctuation regarded as what was going on in families but as inevitable in therapy. As therapists our perceptions and explanations of a family were invariably seen as our own constructions and a punctuation of the process between the therapist and the family. This view gave additional emphasis to the importance of live supervision in family therapy. The therapist needed the supervision team to enable him or her to gain some ability to reflect on their joint dynamics. In turn, it was argued that the supervision team could also only offer their punctuation of the therapist–family system and attempts needed to be made to reflect on this in turn. Regular external consultation was therefore also seen as necessary to reflect on these various levels of interacting systems.

Practice

Hypothesizing

The concept of punctuation was incorporated by the Milan team (Palazzoli et al. 1978) into the idea of therapy as inevitably progressing through a process of hypothesizing. There could be no objective truth about a family, only our subjective perceptions as observers. The best we could achieve therefore was to formulate hypotheses (hunches) about what was going on, which could be more or less helpful in our ways of working. This view broadly encapsulates the pragmatic position of the Palo Alto MRI group in that communication needed to be considered in terms of not only what was intended to be communicated but also what its consequences were. Hence a hypothesis was to be judged in terms not of its ultimate truth or falseness but of how effective it was in facilitating some positive change.

Constructivist approaches have repeatedly drawn attention to the fact that family members may disagree, sometimes violently, about their explanations and narratives. These have been seen as essentially interpersonal disagreements or struggles over the punctuation of events. More recently this has been discussed in terms of the competing stories family members hold and which define previous and future events. The analysis of questions about the meaning of a problem or symptom is similar to the processes of deconstruction employed in the analysis of literature and the social sciences. Deconstruction involves taking constructs apart, analysing and tracing their historical origins, examining their inner logic, exploring their contradictions and inconsistencies, exploring the situations in which concepts are employed and considering what implications there are for action. When we engage in this process with

families it is not unusual to find that the conflicts are not so much about disagreements as about different uses of a concept. Deconstruction can be employed as an activity that invites alternative meanings to be considered, which by opening up the definition of a concept can encourage or at least lay the groundwork for some mutually acceptable definitions to emerge.

Reframing

A key technique or orientation was that of reframing problems (previously mentioned in Chapter 1). Initially it was seen that therapists would offer new or different ways of seeing a problem as an intervention. Preferably this would be a second-order perspective, that is, a new view which completely changed the sense of a problem. For example, conflict in a couple could be discussed as showing a fiery passion and as something that could eventually make their relationship stronger.

Reframing involves offering some fundamentally different ways for a family to see their difficulties, enabling some patterns of actions or attempted solutions to emerge. A reframe requires some profoundly new ways of seeing the situation rather than relatively minor shifts:

> To reframe, then, means to change the conceptual and emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the 'facts' of the same concrete situation equally well or even better, and thereby changes its entire meaning.
>
> (Watzlawick et al. 1974: 95)

For example, Harry, a young boy aged 7, was referred with worries about his strange thoughts, nightmares, bizarre images and refusal to go to sleep at night on his own. There were some concerns that he might be displaying some form of childhood schizophrenia. His mother had recently started a training course and was spending more time away from home, possibly leading Harry to worry that the family was disintegrating. It also appeared that both parents had experienced nightmares when they were children and continued to be worried, especially the father, about any indications of unusual internal states.

As a reframe it was suggested that rather than seeing Harry as potentially ill, he could in fact be seen as a very imaginative and sensitive boy. He was also following in the parents' footsteps in being sensitive in this way. Furthermore, this sensitivity perhaps made him concerned about the changes that had occurred in the family and his thoughts symbolized these. Perhaps Harry also hoped that his symptoms might ensure that his parents stayed together in order to look after him, rather than fulfil his fears that they might be going their separate ways. The reframe of Harry as creative and sensitive rather than odd and ill was accepted by the family and they started to notice confirming views, for example, when one of his teachers commented that she thought Harry was an imaginative boy.

Watzlawick et al. (1974: 123–4) offer an example of the impact of reframing even when the problems have become more acute:

A twenty-five-year-old man who had been diagnosed as schizophrenic and had spent most of the past ten years in mental hospitals or intensive psychotherapy was brought into treatment by his mother, who thought that he was at the verge of another psychotic break. At the time he was managing to live a marginal existence in a rooming house, taking two college courses in which he was failing. He was manneristic in his behaviour and often 'politely' disruptive during sessions. As far as he was concerned, the problem was a long-standing disagreement between him and his parents about his financial support. He resented their paying his rent and other bills 'as if I were an infant'. He wanted his parents to give him an adequate monthly allowance, out of which he could take care of his obligations himself. His parents, on the other hand, felt that past history as well as his current demeanour indicated that he could not handle these responsibilities and would grossly mismanage the money. They, therefore, preferred to dole out the money on a week-to-week basis, with the amount apparently depending on how 'good' or how 'crazy' their son seemed at the time. This, however, was never clearly spelled out, just as the son never directly expressed his anger about this arrangement but retreated into a sort of psychotic clowning around which his parents took as further evidence that he was incapable of managing his own affairs. It also increased the mother's fear that yet another expensive hospitalization might soon be inevitable.

In the presence of his mother it was pointed out to the son that since he felt outnumbered by his parents, he had every right to defend himself by threatening to cause a far greater expenditure by suffering another psychotic break. The therapist then made some concrete suggestions as to how the son should behave in order to give the impression of impending doom – these suggestions being mostly reformulations of what the son was engaging in anyway.

This intervention reframed the son's 'crazy' behaviour as something over which he had control and which he could, therefore, use to his advantage, but the same reframing allowed his mother to see it as just that and be less intimidated by it. One of the results was that during their next quarrel the mother simply got angry with him; told him that she was tired of having to manage his affairs, acting as his chauffeur, etc.; and established an adequate allowance for him, with which he could sink or swim as far as she was concerned. In the follow-up interview, this arrangement turned out to be working well, so much so that the son had meanwhile managed to save enough of his allowance to buy a car, which made him less dependent on his mother.

Co-construction of shared histories

One specific example of an attempt to explore the construction of meanings over time and from different levels of influence is Pearce and Cronen's (1980) ***co-construction*** model. They proposed that the history of a relationship is seen to provide a context within which current actions are interpreted. So the attempts by one partner to be 'nice' may be distrusted if there has been a history of conflict. On the other hand, some unpleasant behaviour may be tolerated if the relationship is defined as 'good'. A problematic situation can occur when there is a fine balance between these

definitions, that is, there has been considerable conflict but also some satisfaction. An ambiguity may occur so that a particular action, such as teasing, can be defined as vindictive if the negative aspects are focused on or, alternatively, seen as fun. However, a couple may also attempt to use the current action to define the relationship, for example, we are having fun so our relationship must be good. Each person may also define the present action and the relationship differently. People seem to refer to such states as 'not knowing where we're at' or 'being at a crossroads'. The higher levels of contexts – the family and cultural scripts – can help stabilize such reverberation, but for people who have had contradictory and ambiguous experiences in previous relationships and in their families (life scripts), the reverberation may continue to the higher levels, so that problems in their relationship may imply that the world cannot be trusted. Possibly this offers another way of explaining so called 'insecure' personalities and relationships.

An important contribution of Pearce and Cronen's (1980) model is that it starts to offer a way of integrating meanings created within relationships with wider societal beliefs, attitudes, norms and values. People in relationships are seen as creating meanings with one eye on the meanings, definitions, expectations of relations prevalent in their local and wider societal context.

Commentary

Second-order cybernetics involved a shift towards embracing *constructivism*, a growing body of theory and research in psychology and other disciplines. At its strongest, constructivists argue that there is no objective reality or truth out there but instead we each see the world through our personal, subjective lenses (Watzlawick 1978). One version of this view emerged from cognitive biology (Maturana and Varela 1980). This resulted from research, particularly on the biology of perception, which consistently failed to be able to identify any straightforward correspondence between, for example, electrical and chemical responses in the retina to various inputs and the experience of perception. This led to the constructivist view that the brain was actively computing patterns internally but that these were not simply determined by external input. In effect the brain could not be 'instructed' by the external input what to experience but actively decided what to experience based on an internal model of the world that had been developed over time.

There had been several moves in the direction of constructivism evident in the development of cognitive psychology, which focused on the nature of internal computing processes involved in memory, perception, attention and learning. Earlier, Piaget (1955) had made major inroads into the study of how children actively learn to make sense of the world. For example, he argued that even our most basic experiences, such as the permanence of physical objects, is based upon a set of assumptions that develop for a child. Initially the world may appear extremely non-permanent since the same object can, for example, look totally different depending on whether we are seeing it from the front, sideways or from the back. To see physical objects requires complex inferences based upon our prior experience of the world.

Moral and political implications

Second-order cybernetics shares with some of the humanistic psychologies a somewhat unrealistic view of the potency of the individual and families. On the one hand there was generally little consideration of the influence of structural factors, such as poverty, unemployment and education, or of the ideological factors, such as the ways in which dominant culturally shared views shape family beliefs. For example, there was generally little recognition that men and women have been socialized into different ways of seeing themselves, their abilities, their emotions and their roles in relationships. Similarly, there was little elaboration of the influence of prevalent ideas about family life and roles, especially gender roles and ideas about parenting, childhood and so on. This lack of concern arguably turned some of the more apparently liberal aspects of second-order cybernetics into a potentially oppressive framework which by implication blamed families (or therapists) for not being able to change themselves. This criticism of course applies to much of psychology in the excessive emphasis that it has placed on the individual or, at best, on relationships while disconnecting them from the cultural context (Hollway 1989). This slippage away from a consideration of the ecological context is perhaps surprising considering that Bateson (1980) and other biologists (Maturana and Varela 1980) were also immersed in evolutionary metaphors which stress the interdependence of organisms and systems with their environment.

Second-order cybernetics challenged the visions of first-order cybernetics of what constituted a 'normal' or 'healthy' family (families in which symptoms functioned in order to preserve homeostasis were in essence regarded as pathological and in need of remedial intervention) and argued that it was the way family members saw their difficulties that in part resulted in problems. The problems did not have an objective existence as such, but by seeing their situation differently change could be produced. The goal of therapy shifted from attempts to remove symptoms as the first priority to encouraging more productive ways of seeing things.

A criticism of second-order cybernetics, especially the constructivist dictum that there is no reality but only our perceptions, is that it can lead to a therapeutic approach that plays fast and loose with truth. Since there is no reality, then, in effect we can invent anything and say anything in therapy as long as it works. However, we cannot even be conclusive about anything 'working' since this also involves adopting a position of truth which cannot be sustained. The best we can hope for is that family members tell us that they think things are better and we choose to accept this.

At its furthest extent, the extreme relativism of second-order cybernetics and constructivism leads us into some impossible dilemmas regarding problems such as physical violence, sexual abuse, emotional abuse, and so on in families. Also a whole range of structural factors, such as poverty, racial and sexual discrimination are reduced to being seen simply as perceptions rather than real factors which shape and constrain people's experience. Do we end by saying that these do not really exist but we just have beliefs about their existence? There is a great danger in adopting a naively pluralistic and liberal political standpoint which ultimately condones the political status quo and patterns of inequality and oppression in society.

Power

Constructivist approaches and systems theory more broadly can give the impression that each member of a relationship has equal power to determine how relationships shall be defined, what meanings are given to particular actions. However, this may not be true. Children, for example, may be at the mercy of their parents in forming a view of themselves and important events in the world. The power of parents may not be total in this but nevertheless it can be very naive and oppressive to children not to be aware of the ways that their perceptions and beliefs may be 'programmed' for them. Likewise, the more powerful person in a relationship may be better able to impose his or her views, perhaps in subtle ways through the use of their prestige, educational status, greater experience of the world, and so on. Moreover, as we will see in the next chapter, power to define the relationships in ways that privilege one partner is also partly conferred by virtue of our location in society. For example, societally shared views about gender roles, children, race and so on can be enlisted to define the relationship. One powerful tactic, for example, is for one partner to make reference to what is 'normal' and expected.

Milan approaches

The style of the Milan team was extremely elegant, complex and has continually evolved. Our inclusion of it here as a strategic approach perhaps is representative of its early appearance in the field.

A team of therapists in Milan dramatically adapted strategic approaches, particularly in terms of paying much greater attention to the underlying beliefs held by family members. Arguably the approach that was developed is distinct in many ways and should be considered separately. We suggest that originally it shared the most fundamental premise of strategic approaches which is that therapists act tactically towards families. They do not share their analysis of the problems nor volunteer their therapeutic orientations or plans.

We have suggested that both structural and strategic approaches described so far are based on a systemic model in emphasizing how symptoms in one or more members need to be seen as arising from and maintained by the patterns of actions of the members of a family. However, the Milan group utilized one of the purest forms of a systemic approach. Most importantly, they suggested that it was conceptually wrong and therapeutically futile to allocate any sense of blame for the actions of the non-symptomatic members of the family. They argued that a systemic view fundamentally regards the actions of all of the family members not as negative, but as the best that they can do. Another way of seeing this is that the intentions may be positive even if the outcomes are not. A key to this approach was that they developed a strong interest in the underlying premises and beliefs that guided families' actions. Rather than seeing these as merely relevant but in some ways peripheral to therapy, the underlying beliefs or premises held were seen to be of central importance:

> Our interest moved from symptoms and behavioural patterns to epistemological premises and systems of meaning and from the present to a time framework that included past, present and future. The therapist's job became that of creating a context for deutero-learning (i.e. learning to learn) in which the client could find his own solutions.
>
> (Boscolo and Bertrando 1996: 10)

Positive connotation

This technique, which shares features of reframing, was developed to encourage the therapist to view and subsequently reflect back to the families a positive reason for all of their actions. As such, it was a fundamental adjunct to paradoxical directives. Rather than simply offering a directive to a family to maintain or even increase a symptom, such a suggestion was supported by providing a rationale for why each and every member was acting in the way they were. This neutral, non-judgemental position also placed the actions of all of the family members on an equal footing and militated against the tendency to see members as victims or victimizers. The positive connotation might commence with a global statement, such as 'All the observable behaviours of the group as a whole appeared to be inspired by the common goal of preserving the cohesion of the family group' (Palazzoli et al. 1978: 56). Subsequently there would be an elaboration in terms of the roles each of the family members was playing in ensuring this cohesion.

For example, Mr Bailey, now in his fifties, had been repeatedly hospitalized for a form of depressive illness. The dominant family story about this was that his problems resulted from having experienced shell shock in the Second World War. The family consisted of Mr Bailey and his wife, two adult daughters (Kathy and Pat) who had recently left home but visited to see their mother every day, and the youngest child, also adult but who was still living at home (he refused to attend any of the sessions). In therapy they complained of interminable bickering – a 'family at war' – and mainly put this down to Mr Bailey's problems and awkward personality. The story of the home situation was that Mr Bailey was excluded from all aspects of family life and was regarded with some contempt, especially since his wife was the breadwinner. This exclusion was confirmed in the session with the women, especially the daughters making faces and laughing when Mr Bailey talked, which was usually in a characteristically rather forceful and emotive manner.

A positive connotation was introduced through a discussion of the roles that the various members of the family played:

Therapist:	Can you tell me about the roles that people play in the family? Who is the artistic one? Who is the scientific one? Who makes the decisions? Who gets most upset? Who has the worst temper?
Mr Bailey:	Well, Kathy is the intelligent one, with her qualifications and everything.
Mrs Bailey:	And Pat is the artistic one.
Kathy:	I think Dad has the worst temper, but I'm a bit like him.
Mr Bailey:	Mum makes the decisions.
Therapist:	So, who is the peacekeeper?
Mr Bailey:	Well, there isn't one. That's why we are here . . . We are like a boat with a hole in it that's sinking.

Therapist: But someone must be putting their finger in the hole. Otherwise it would have sunk . . . I wonder whether Mr Bailey puts his finger in the hole sometimes?

Mrs Bailey: Perhaps tries to keep the peace in his own way?

Pat: Well I'm more confused than ever now. I always thought Dad was the reason we had all the problems.

Therapist: Well, the boat would have sunk by now if no one had put their finger in the hole, but you've been together a long time. I think that you are trying your best to keep the boat afloat in your own ways.

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Skill guides

As with the skill guides offered in Chapter 1, the following have been selected to offer a flavour of the nature of therapeutic techniques and approaches evolving from this phase. In addition, the approaches chosen in our view continue to be extensively employed by many therapists and adapted to fit contemporary orientations.

Teamwork

Background

With the publication in English in 1978 of *Paradox and Counter Paradox* by Palazzoli et al. in which the ritual five-part session was described, teamwork assumed greater importance in the field. The key element of teamwork is the synergy developing from team members sharing ideas, based on feedback. This process requires a certain rigour and individual willingness to give up one's beloved ideas (for hypotheses or interventions) and contribute instead to letting new ideas emerge in team discussion.

Usefulness and relevance

Teamwork could be said to embody second-order cybernetic and co-constructionist practices and thus is an important skill, not least because it demonstrates a congruence between theory and practice. For individual practitioners and therapists, good teamwork provides uniquely creative and supportive experiences with colleagues, in addition to promoting good practice.

Exercise: the sequential discussion

This exercise was designed to develop the rigour required for good teamwork and to encourage co-working rather than individualism.

1 In a group (say four to eight persons) a topic is chosen for discussion in sequence. Group members do not have to speak in any order (for example, in turn, clockwise or anticlockwise) but the group must ensure everyone has a turn to express an opinion or ask a question in round one, before the group moves on to a second round of discussion.

2 Whenever a group member speaks they must first comment on what the previous person has said and then add only one new idea of their own to the discussion.

3 Each group member's comment should be brief and allow the discussion to go round the group four or five times.

4 Group members are encouraged to offer their ideas to the group and let the discussion develop through the group's process rather than through individual group members developing their own ideas.

5 After 10 minutes, the discussion ends and group members spend 5 minutes or more reflecting on the experience.

Further reading

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Hypothesizing

Background

While it is our view that we all hypothesize consciously or unconsciously as we make therapeutic decisions about how to intervene, we recognize that the work of the Milan associates from the mid-1970s onwards introduced a more explicit hypothesis-making activity to the field of systemic practice.

Usefulness and relevance

The Milan associates carefully distinguished between the use of hypothesis in the scientific sense or a hypothesis to be proved (a self-fulfilling prophecy) and hypothesizing in the context of systemic therapy, which was a way of organizing information and feedback to provide a guide for the therapist's activity in conducting an interview. Because a hypothesis can be more or less useful and not true or false, a hypothesis allows the therapist to hold on to a view of the family's behaviour that is different from the family's and thus potentially challenging and useful to family members looking for change.

Exercise

In order for practitioners to learn the art of generating and appreciating the usefulness of many possible diverse hypotheses (or possible meanings for problem behaviour) the following exercise introduces some ritual and rigour to the process of hypothesis-making.

Participants are asked in respect of a family/client problem to complete the sentence:

A I have a hunch that

_____

(Inserted here are one or more of the practitioner's ideas for explaining the presence of problem/symptoms.)

Then participants are asked to complete sentence B:

B And therefore I am interested in finding out more about

_____

(Inserted here are several possible avenues of inquiry the practitioner can think of which must be different from what is stated in A.)

We give below an example regarding Johnny, a school-refusing 12-year-old boy:

A *I have a hunch that* Johnny does not go to school because he worries about his mother being alone and lonely at home without him.

B *And therefore I am interested in finding out more about:*

1 How much time Johnny's mother and father normally spend relaxing together.

2 What the family patterns are for achieving independence.

3 What interests Johnny's mother has in her life apart from child-rearing.

4 How Johnny's father and mother negotiated independence from and with their parents.

5 What kind of relationships Johnny has at school with his peers and what out-of-school friendships he has.

These five possible areas of exploration demonstrate the possible richness of disciplined inquiry based on hypotheses providing a focus but not seen as a foregone conclusion.

Positive connotation

Background

Positive connotation is a therapeutic device most usually associated with the Milan associates and originally designed to provide a 'logic' for symptomatic behaviour that would be consistent with therapists' declared recognition of the value for all family members of the status quo and which included the symptomatic behaviour. According to Palazzoli et al. (1978: 86):

> it thus became clear that access to the systemic model was possible only if we were to make a positive connotation of both the symptom of the identified patient and the symptomatic behaviours of the others, saying, for example, that all the observable behaviours of the group as a whole appeared to be inspired by the common goal of preserving the cohesion of the family group.

Usefulness and relevance

This is an important skill for therapists wishing to successfully join with families as it enables an appreciation of the way symptoms can fulfil a stabilizing function (however temporary) for families to be shared. Recognition and appreciation of the usefulness of symptoms is the first step towards dissolving a symptom. As a development of reframing, positive connotation requires the therapist to explicitly appreciate the logic and noble intentions of family members' behaviour, thus reducing the family members' need to resist the therapist's attempts to offer the family alternative meanings. It is widely recognized that nobody ever changes under a ***negative connotation***.

Understanding how to positively connote family situations and relationships is indispensable when attempting to prescribe the symptomatic behaviour and/or offer families a paradoxical intervention. It can be said that positively connotating symptomatic behaviour is a paradoxical intervention in action.

Exercise

Each step is to take no more than 5 minutes.

1. In trios, practitioners A, B and C take it in turns to describe a client family situation in which they find themselves frustrated and feeling negative towards family members.
2. A then listens, while B and C discuss what might be ways to begin to appreciate how family members are attempting to care for one another by certain behaviours; B and C may also choose to speak as if they were family members.
3. A then attempts to describe how she or he is developing an appreciation of the logic of the family behaviours and to make a positive connotation of the symptomatic behaviour.

Further reading

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Circular questioning

Background

Asking questions in this way radically changes the process of therapy. ***Circular questioning*** is an original feature of the Milan associates' systemic model, which enables therapists to become genuine inquirers and to ask questions of family members on the basis of feedback to the information solicited about family relationships and, therefore, about difference and change. The differences asked about are various family members' perceptions and beliefs about the meaning of events, relationships, and so on.

Usefulness and relevance

To be a genuine inquirer and not to 'know' but to believe the conversation developed using circular questioning, thus illuminating distressing situations and leading family members to see new options and possibilities, is a valuable skill for therapists. The style of interviewing can have the effect of empowering family members and therapists alike.

Exercise

Participants are asked to work in trios (A, B and C).

A chooses a neutral topic to be questioned about, for example weather, holidays, food, travel. B asks questions based on feedback and attempts to establish the relationship between A's beliefs and behaviour on the topic as well as to map a system of significant relationships around the topic and the effect these all have in A's life.

After 10 minutes, B and C discuss, with A listening, a focus for the second half of the interview which C then conducts while B observes.

At the end of the second 10-minute interview, A is invited to share any ways in which his or her beliefs have altered, been challenged or become more certain.

Each member of the trio (A, B, C) has the opportunity to observe, be interviewed and interview. There can then be a discussion about the experiences in each of the different positions.

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Transformational change

Background

Throughout the 1970s and 1980s there was debate about so-called first- and second-order change and how changing the 'rules' that governed family members' behaviour was the transformational change sought by systemic therapists for their clients and not merely a change due to the relief or the catharsis of being listened to by a sympathetic professional person. Examples in everyday life of transformational change are learning to walk, swim, drive or fly; after such experiences, the world for the toddler, swimmer, driver or pilot will never look the same again. Thus we say with clients the 'rules' of behaviour have changed.

Usefulness and relevance

Without an understanding of transformational change, practitioners are not able to identify when family 'rules' do change or recognize when something changes in a

family but the 'rules' remain the same and thus relationships too stay the same, leaving a family vulnerable to symptoms returning or new symptoms developing.

Exercise

Participants are asked to bring a pear to a class and are invited, one by one, to describe their experience of selecting and bringing the pear to the group and any other thoughts and feelings they care to share. Invariably someone in the group says, 'After this pears will never be the same again'.

The group leader, having heard the group's pear stories, invites the group to hear about a different kind of PAIR (Practice, Application, Ideas, Reflection and Reflexivity) as he or she talks to the group about the elements of learning and change in their professional development. The elements of the PAIR in this case represent elements in teaching the learning processes, and the group leader changed the rules, that is, spelling in order to illustrate the importance of transformational change.

Further reading

Watzlawick, P., Weakland, J.H. and Fisch, R. (1974) *Change: Principles of Problem Formation and Problem Resolution*. New York: W.W. Norton.

3

The

3

The third phase – mid-1980s to 2000

> I sometimes think that 99 per cent of the suffering that comes in through the door has to do with how devalued people feel by the labels that have been applied to them or the derogatory opinions they hold about themselves.
>
> (Hoffman 1993: 79)

Cultural landscape

The third phase is characterized by a growing awareness of the social and cultural contexts that shape both families' and therapists' beliefs. The seeds for this movement had been germinating especially in the work of therapists inspired by feminist perspectives and more broadly in the emerging social constructionist theories. These were articulated, for example, in the USA by Ken Gergen, Lynn Hoffman and others, in France by Michael Foucault and in Australia by Michael White. Outside family therapy the roots of social constructionism lay in attempts to explain the phenomena of prejudice, racism, gender stereotypes and sexualities. Inspired by feminism in the USA, there was an increasing sensitivity to and interest in the way language contained the heritage of ideas and assumptions of any given culture, for example, in the hitherto unquestioned usage of terms such as 'housewife', 'chairman', 'primitive culture', 'neurotic' and 'mentally ill'. The accumulation of critiques of family therapy led to a realization that family life, including the development of 'problems', was fundamentally shaped by language. Just as feminism had raised awareness of the nature of sexist conversation in the workplace and in education, similarly awareness increased of the power of conversations in families to create experience.

The development of this third phase has come from both inside family therapy from observations of therapists in the USA, UK and Australia in particular and also from outside family therapy in the tide of social constructionism and its powerful impact on the social sciences. Possibly the development has been most apparent in countries, such as the USA, UK, Scandinavia and Australia, where there has been a strong feminist movement. In France, though the writing of Foucault has been important and widely recognized, the context is more exclusively linked to Marxist and existentialist theory than to feminism and family therapy.

Theoretical perspectives

The third phase of systemic family therapy represents a move towards social constructionist theory. In fact some have argued (White and Epston 1990; Hoffman 1993) that what is involved here is not just a development but the end of systemic theory and therapy! We will first outline social constructionist ideas and suggest that, as is often the case, the cult of 'disposability of ideas' – a 'social amnesia' for the relevance and continuity of ideas (Jacoby 1975) – is mistaken and unhelpful.

Social constructionism proposes that commonly seen patterns of actions in families are not just produced by the idiosyncratic dynamics of each family but necessitated by the demands of the wider society that a family is located within. Frequently observed patterns, such as that of the 'over-involved' mother and 'disengaged' father, need to be understood more broadly as being determined by the wider societal structures and ideologies which shape family life, especially the relations between men and women:

> The pattern of family behaviour so frequently encountered by family therapists, that of the 'over-involved' wife/mother and disengaged and absent husband/father, suddenly appears in a new light: as a necessary form. That necessity derives from its ability to reproduce the personality characteristics, relationship patterns and behavioural orientations that are functional for continual operation of the contemporary social formation.
>
> (James and McIntyre 1983: 126)

Despite social changes, women are still more likely than men to carry the burden of care for children and to be more centred around the home. This is not simply a personal choice but one shaped by a variety of economic and practical necessities dictated by the society they live within. However, associated with any given society are a web of discourses or ideologies, such as that women are 'naturally maternal' since they are seen to be more emotionally responsive, nurturing, non-competitive and so on. In this way a set of roles and beliefs about family life are reproduced across the generations.

General systems theory does not take account of the wider societal factors that shape the patterns of interactions observed by family therapists, and this has been seen by some as a major indictment and testimony of its failure (James and McIntyre 1983; Williams and Watson 1988). However, it has been suggested in contrast that in fact second-order cybernetics can be utilized to take such factors into account:

> The second-order cybernetic view argues, in a manner similar to that of the feminist critics, that it is the observer (or therapist) who draws distinctions that 'create the reality' . . . By including the observer as part of the system observed, second-order cybernetics acknowledges that the system considered relevant is a construction of the observer drawing the distinctions . . . Drawing distinctions is thus not only an epistemological act, it is a political act.
>
> (McKinnon and Miller 1987: 148)

As therapists become increasingly aware that the 'reality' they observe is a cor struction, they may also become aware that their perceptions are shaped by the culture. However, though seemingly obvious, this step to a cultural awareness was, a McKinnon and Miller argue, not an inevitable one. Instead, many therapists becam distracted by an emphasis on subjectivity – that what was seen was part of the personal baggage. One of the contributions of social constructionism has been t draw attention to the fact that such subjectivity can only be partial since even th words we employ in our 'private' internal conversations are soaked in the legacy c meanings of our cultural contexts.

A variety of societal influences may shape people's experiences in familie including institutionalized structures and practices. Adequacy of housing, incom type of locality, and educational opportunities are determined by the family's positio in the socio-economic pecking order. Dominant shared beliefs or ideologies defin expectations, ideas of identity, gender and other family roles, and a system of per ceived rights and obligations. These beliefs may shape not only the practical, mor obvious aspects of life but even the most intimate, supposedly 'private' moment such as expressions of sexual intimacy and moments of family sorrow and joy. Eve in our moments of solitude our private internal reflections consist of verbal dialogue and images which are imported from our cultures. For example, the words an phrases that we use in speaking with our self connect us to our immediate and histor ical cultural legacy of ideas and meanings. Feminist analyses have been particularl helpful in drawing attention to how language itself contains and perpetuates a variet of assumptions, directs our attention and may perpetuate ways of thinking whic support inequalities, for example, in terms like housewife, 'good' mother and singl parent.

The production of dominant systems of ideas and meanings – ideologies – i regarded in social constructionism as shaped and maintained according to distribu tions of power. As a telling example, people of the lowest socio-economic groups an ethnic minorities generally have poorer physical and mental health: put simply, the die younger and appear to have generally more tormented lives. However, unti recently it has not been acknowledged that these differences are due to basic inequal ities in our society but due to 'poor health habits', 'fecklessness' and so on. The crushing effects of poverty and stress have been frequently minimized in terms which extol the virtues of personal autonomy and choice. Such conceptualizations can be regarded as systems of knowledge or ideologies which serve to disguise or justify the privileges of the most powerful groups. In short, the dominant classes have privileged access to a variety of means, education, the media, commerce and industry to promote systems of thought which maintain their superior opportunities and position: 'The ideas of the ruling class are, in every age, the ruling ideas . . . the class which has the means of material production has the means of mental production, so that in consequence the ideas of those who lack the means of mental production are, in general, subject to it' (Marx and Engels 1970: 35).

Foucault (1975) has been highly influential in pointing out that in any given culture there can be seen to be dominant narratives or discourses. In the early days of psychotherapy, for example, the dominant narrative had been that problems were due to individual factors or disorder. With the advent of interactional approaches the

dominant narrative has moved, to some extent, to a view that problems are due to a variety of transactional processes within the family. Though family therapies have argued for a 'neutral' approach, a systemic approach has been seen more critically from the outside, for example, by parents' rights groups, as accusative, blaming and implying that family dysfunctions cause the pathology.

Connections and links to the second and first phases of systemic family therapy

Social constructionism contains a number of premises which can be seen to be closely related to systemic ideas. These include an emphasis on context and interpersonal processes in creating joint actions and mutually constructed meanings, strategic interaction, an acknowledgement of the importance of power and on the exchange of ideas or feedback. Social constructionism argues that meanings are jointly created through the dynamic processes of conversations. Rather than focusing on individual characteristics or traits, the focus is on how individual experience is fundamentally social and interpersonal. Individual identity and the self are not seen as stable or monolithic, rather identity is seen as fragmented and distributed across social contexts. For example, a child may act and feel like a different person according to whether he is with his parents, siblings, mother or father, the therapist, at school, and so on. We are shaped by the interactions across different contexts in which we are involved.

These interactions are seen to be recursively shaped by the use of language which is regarded as active and *strategic*. People are seen as continually employing 'rhetorical devices' in the use of language to achieve particular ends and goals – to persuade, accuse, justify, solicit sympathy or admiration, seduce, and so on. A variety of linguistic strategies are seen to be employed to achieve these ends, such as humour, presenting arguments *in extremis*, emphasizing one's honourable intentions, use of metaphor and reference to stereotypes (Potter and Wetherell 1987). In effect this emphasizes that we are all strategic interactants and that therapy therefore needs to be able to take this into account. This connects with the emphasis of strategic therapies that recognize the need to consider the therapist–family encounter as inevitably a strategic one (Haley 1963, 1976a). Related to this is an emphasis on power. Social constructionism emphasizes that interactions are invariably connected to power and that language use defines power, for example, by our sophistication with language, our accents, our access to specialist knowledges inherent in different languages, such as specialist scientific and medical languages.

Importantly, social constructionism also emphasizes that meanings and identities in interactions are dynamic and prone to escalations. For example, in a family there can be an escalating process or polarization whereby people are ascribed increasingly divergent meanings and identities. Typically this may mean that one person is increasingly assigned to an identity as the 'ill' member, in contrast to the others who are 'well'. These processes of polarization can be seen similarly in systemic terms, such as escalation and feedback. In social constructionism conversations can also be seen as proceeding on the basis of mutual influence or feedback. An important difference is that, unlike the early systems theories, this feedback is not described in terms of

'information' but as an exchange of meanings. However, the emphasis on meanings was evident in Bateson's (1972) writing, rather than the more mechanistic analogy of families as simply exchanging information which gained some ascendancy in the first cybernetics. However, the emphasis on meanings with the greater possibility of transformation of systems through, for example, 'reframing' was central to second-order cybernetics.

Both systemic theory and social constructionism also emphasize the importance of contexts and how these are internalized into the dynamic of family interactions. Perhaps systemic theory has until recently paid less attention to the wider social and cultural contexts, though the importance of the wider social contexts and family dynamics has been explored, for example by feminist systemic therapists who have developed detailed analysis of the links between subjective experience in families and dominant cultural discourses and structures (Goldner 1991; Hare-Mustin 1991). Goldner (1991) convincingly described how patterns of abuse and violence in couples' relationships embodied a range of cultural expectations about gender roles and male and female identities which helped to construct and legitimize patterns of abuse. Similarly, an analysis of child abuse revealed the operation of pernicious patriarchal assumptions, including expectations of men's right to dominate in families and to employ violence to ensure compliance.

In summary, there can be seen to be much in the way of links between social constructionist and systemic perspectives which invite us to consider the potential of viewing social constructionism as offering some ideas which extend but also connect with systemic theory.

Influential people and ideas

Social constructionism has a lengthy and extended history in the social sciences. It is based in sociology but overlaps with social psychology in its interest in interaction and the study of group (for example family) processes. Rather than adopting a broad or macro level of analysis as sociological theories had predominantly been interested in, social constructionism was interested in developing theories about the links between individual experience and society. Perhaps one of the most vivid metaphors used was that of the 'looking-glass self'. Mead (1934) and Cooley (1922) proposed that our identities, our sense of self, were constructed from the social interactions that we take part in. In these interactions others act like a mirror in presenting us with images of our self. People are seen as fundamentally social: without others to interact with we cannot have a self. The myriad of reflections over time serve to build up some consistent or enduring sense of who we are, an identity. Others, especially parents at first, also initiate us into the common values, beliefs, expectations of our culture. We gain not just a sense of a specific self which would reverberate with every new interaction but a more general sense of self in terms of how we compare with images of what it is, for example, to be a man or a woman, a teenager, black or white, a brother or a sister, a mother or a father.

> Social constructionism presents [family therapy] with a range of new distinctions ... [it] turns to ... the intersubjective influence of language and culture ... it

references knowledge neither in the observer nor the observed, but rather in the place between the two, in the social arena among interpreting subjects.

(Pare 1995: 221)

Key people, places and events (bird's-eye view)

An influential view in this phase is seeing families as 'problem-determined' systems (**Anderson** and **Goolishian** 1988a). This means that it is not the dynamics which cause the problems but more that the problem-saturated ways of talking about difficulties can produce problems. Conversations which focus on families' experiences as evidence of illness, inadequacy, blame and failure keep them locked into narrow ways of seeing their actions and experiences and produce and maintain pathology. Though family conversations are seen as key to this process, blame is not ascribed to families. Instead, it is suggested that these conversations are shaped by the built-in assumptions inherent in the language that they have available to discuss their relationships.

It is acknowledged in the third phase that there is a pernicious influence of factors outside the family's control so a more neutral view of problems follows. In effect, pathology is seen as inevitable, for example, where ethnic minorities experience racial abuse and discrimination, or where women are confined to drudgery, or where poverty and deprivation are seen to strip people of their self-respect and foster a sense of hopelessness. Families are viewed as a microcosm which reproduces rather than causes these difficulties.

The 'problem-determined' system (Anderson and Goolishian 1988a), *The Reflecting Team* (**Andersen** 1990), the work of **Michael White** and **David Epston** with narrative therapy and the Just Therapy Group provide a framework for understanding developments in theory and practice during this third phase. The importance of the 'self of the therapist' also becomes a dominant theme. The debate between intrapsychic and interpersonal approaches then focuses more on integration and a 'both and' perspective rather than on 'either or' as previously.

The social constructionist perspective brings into focus a number of questions:

1. Are disagreements in relationships fundamentally interpersonal or related to wider conflicts and contradictions within and between competing societally shared beliefs or discourses?
2. Is it possible that some narratives, by virtue of being different from the dominant societally shared ones, are seen as deviant and are marginalized, excluded or punished?
3. To what extent do family members create their own narratives or predominantly draw from and adapt narratives from a societally shared pool?
4. Do some of the distortions or fabrications occur because of attempts to contort personal experiences into common socially acceptable ones?

Social constructionist approaches overlap with, but also differ from, the constructivist approaches outlined in the previous chapter in proposing that the beliefs held by family members are not simply personal or familial. Instead, it is argued that

people in families absorb the beliefs or discourses which are common to the partic culture within which they exist. In particular, these common beliefs are seer be embedded in the common currency of language. Rather than seeing langu as relatively passive and as used to describe the world and family experien language instead is seen as involved in creating this world. Language is seen to cor tute social experience, and the way that people speak about events constructs th Furthermore, it is suggested that it is not simply the way families communicate th central but that language contains with it, often implicitly, the 'history of ideas' of culture. To take some simple examples, the terms available to describe family r carry implications about who performs them, such as mothering. Terms such neurotic and hysterical have been predominantly applied to women and shape t personalities and family roles. Even more broadly, Palazzoli et al. (1978) have poir to the dearth of language available to describe interpersonal as opposed to perso processes. Language habits also draw us into particular ways of making sens events; for example, saying that someone 'is angry' rather than that they may 'showing' anger. Frequently we are not even aware of how these linguistic conventi implicitly lead us to particular ways of explaining events. Most obviously this le to the tendency to define problems in personal rather than interpersonal ter Accompanying this is also the danger that we ignore these wider cultural assumpti contained in language and other forms of symbolic representations.

However, just as second-order cybernetics represents a significant shift in field, the third phase, characterized by social constructionism, does not represe complete rejection of the influence of general systems theory or constructivism systemic and family therapy practice. Social constructionism is, after all, fun mentally an interactional, interpersonal model. The second-order cybernetics vie that problems arise from the personal, idiosyncratic perceptions and beliefs held family members.

Constructivist approaches have been invaluable in highlighting how the bel that family members hold serve to shape their actions, choices and attempted so tions to what are perceived to be the problems. They also add an important dyna component in stressing how disagreements between members of families are ofte the root of relationship struggles and failed patterns of attempted solutions to pr lems. Also, the idea of preferred views is helpful in revealing how the struggles c meanings can be seen in terms of attempts to remain true to a positive, desi narrative about one's life or a narrative in which the self is located in a posi valuable role. However, these preferred views can be seen as not simply perso preferences but as shaped by shared societal values, norms and ideologies.

Arguably the foundations of social constructionism and the feminist influence family therapy can be traced to the influence of Marxist theory, in particular proposition that dominant groups in society have the power to produce and sust dominant beliefs or ideologies. The dominant sections of society – predominar white, male and upper-class in Western societies – are seen as able to disseminate a enforce by a variety of practices beliefs which suit and maintain their positions dominance. These ideologies may also serve to distort, as in the popular and pernici view that society is structured according to fundamental abilities and that the poor in that position because they have less ability, are less intelligent or do not want to wo

View of the person – construction of experience

The dominant narratives can be seen to both shape our futures – what we expect, aspire to, images of existence – and at the same time shape the past – how we make sense of what has happened. Like buying clothes off the shelf, we attempt to fit our experiences into the narratives that are available:

> There exist a stock of culturally available discourses that are considered appropriate and relevant to the expression or representation of particular aspects of experience . . . persons experience problems which they frequently present for therapy when the narratives in which they are storying their experience, and/or in which they are having their experience storied by others, do not significantly represent their lived experience, and that, in these circumstances, there will be significant aspects of their lived experience that contradicts this dominant narrative.
>
> (White and Epston 1990: 27–8)

These narratives may in turn shape our aspirations and dreams, they map what we believe to be possible and desirable – for example, spontaneous romance and mutual compatibility, harmonious family life – and we may experience distress when our experiences do not appear to fit or match up to these ideal narratives. As another example, childbirth is surrounded in narratives of joy, self-fulfilment, closeness of the parents, and so on, but the reality for many may involve elements which do not fit – tiredness, irritability, self-doubt, distance and lack of intimacy between the parents. The more strongly this ideal version or narrative is accepted as the 'truth' of how things should be, as normal, the more distress and guilt people may experience if their experience appears not to fit this (La Rossa 1986; Carter and McGoldrick 1989). Such ruptures between our preferred narratives, or societally sanctioned dominant narratives, and what we are actually experiencing can, as we saw in the previous chapter, set in motion patterns of failed attempted solutions which are driven by attempts to reconcile our preferred views with a view of ourselves as incompetent, abnormal or deviant.

Social constructionism shares with systemic theory an emphasis on the centrality of relationships. We only become people through being involved in a social world of meanings through our interactions with others. It also shares with constructivism a view of people as actively engaged in formulating meanings, attempting to understand, predict, plan and reflect on their own and each other's actions (Gergen 1985; Goldner 1991; Hoffman 1993). In addition, it emphasizes that all aspects of our existence are fundamentally social; from the moment of birth we can be regarded as immersed in a social world which offers us not only a view of the world but also epistemological orientations, ways of knowing or thinking about this world. Rather than predominantly starting with a perspective on how the individual is actively making sense of his or her world, this process of making sense is itself seen as socially constructed and mediated activity.

In social constructionist theory, 'madness' is not an objective phenomenon but a construction – it is a label given to certain actions within a particular culture.

Arguably in another culture the same actions might well be defined in alternative ways.

This emphasis on culture and ideology or discourse starts to separate social constructionism from constructivism. In effect, though interactions are central they are seen as also shaped by commonly held ideology and discourse – sets of interconnected beliefs held in common in any given culture. Early social constructionism, however, could be seen as pluralistic in that society was seen to be composed of a range of competing or contested discourses. However, fuelled by input from feminist theories, which in turn were based in Marxist analysis, social constructionists have argued (Foucault 1975; White and Epston 1990) that the discourses that are available in a given culture at any time are intimately linked to structures of power. As an example, until recently men have had the power to define what were acceptable female identities; women could not vote, they were supposed to stay at home with their children, were not expected to enter professions or to be sexually aggressive. Similarly, inequalities between races have been maintained by a combination of structural power, which in turn can shape ideological power. Such an analysis represents some stark contrasts to constructivism. Rather than seeing people as inevitably free to construe the world in their personal and subjective ways, social constructionism proposes that in any given culture there are common materials, building blocks, from which identities and relationships are constructed. Further, some members of our society have more power than others to design and construct identities; for example, members of the medical profession have the power to assign a variety of labels, such as schizophrenic or anorexic, to people. In turn, members of the medical profession are required to act in certain ways as part of their position in the social order, they are not simply free to do otherwise.

Some key family therapy concepts, such as the idea of family life cycles (Carter and McGoldrick 1980), strike chords with social constructionist ideas. For example, the family life cycle embraces the idea that each of us is simultaneously involved in a variety of social groups, for example, a woman in a family may simultaneously be a mother, a worker, a daughter, a lover, middle-class, white and most generally a woman. Our sense of self is therefore seen as fragmented, complex and multiple. At any given moment and in different contexts one aspect of our identity may dominate over another. There may also be strains and conflicts between these different identities which are defined by the various social systems that we belong to, for example, the identity of a mother and career woman. These societally constructed identities may themselves shift and leave us with ambivalent or contradictory images of our self, for example, the shifting ideas of masculinity and fathering may leave many men confused about what sort of person they should be. Social constructionism suggests that our social world is actively created by the interactions between and within groups of people in society. What is created is a set of ideas, or shared beliefs, ideologies which lead to various practices, including ideas about what the structure and behaviours comprising families should be like. More widely, the practices or regimes that follow define our access to money and housing, work opportunities, educational structures and a variety of intrusive measures, such as surveillance of the care of children, acceptable behaviour inside and outside the home.

An important difference between constructivism and social constructionism is that the latter takes as its central point that there are social realities. It is not simply suggested that there is a 'real', objective world 'out there' but that there are dominant beliefs, explanations, ways of thinking about the world, and in particular a shared language which construct how we see the world. The fact that these socially constructed views continually change does not mean that at any given moment or point in history they do not have a real existence as influential shared ideas. This sensitivity to how families are immersed in the reality of their culture highlights how constructivism, in contrast, tends to isolate families from society. Instead of simply exploring new narratives, a social constructionist approach to therapy tries to consider how a family's creativity is shaped by dominant narratives, and what is co-constructed in therapy must engage with this wider societal system of beliefs. Such therapy often includes an explicit discussion of these societal beliefs, as in the approach of Goldner et al. (1990), where couples are encouraged to critically discuss how their ideas are shaped by the commonly held expectation of gender roles and male–female relationships.

White and Epston (1990) argue that it is this fundamental view that a scientific approach can establish the objective 'truth' of disorders that is a central political issue in therapy. More specifically, this view also regards societal or even relational factors as secondary if not irrelevant. Many families can be regarded as having been immersed or indoctrinated into such a view and therefore see their problems in such a 'problem-saturated' way. However, this scientific view of problems is related to power, for example, the power invested in the medical profession or the power of dominant sections of society to define problems as signs of personal weakness rather than as indications of social inequalities. To challenge these definitions is also, in effect, to challenge the existing structures of power:

> In joining with persons to challenge these practices, we also accept that we are inevitably engaged in a political activity. (We would also acknowledge that, if we do not join with persons to challenge these techniques of power, then we are also engaged in political activity.) This is not a political activity that involves the proposal of an alternate ideology, but one that challenges the techniques that subjugate persons to a dominant ideology.
>
> (White and Epston 1990: 29)

Social constructionism is not a simple and systematically organized theory. At least two strands can be detected. On the one hand it can be employed to offer a view of human experience as a 'top-down' process, whereby we are shaped by our internalization of dominant discourse (Hollway 1989). This in turn is seen to be related to structures of power in any given culture so that until recently, for example, in Western societies male discourses had come to be dominant. A more 'bottom-up' slant is offered by Foucault (1975), who stressed that discourses are reproduced, transformed and have their impact in local, day-to-day interactions and conversations. Hence, ***discourses*** are not easily identifiable, objective entities, but continually shifting waves of meanings. Nevertheless, both slants suggest that there are dominant ideas which have powerful consequences. White (1995), in particular, argues that medical discourses of mental health have had a consistently negative impact in shaping people's experiences and, most importantly, in legitimizing practices, such as exclusion and confinement and creating 'spoilt identities' through the processes of diagnosis, leading to labelling and stigmatization.

Practice

The third phase is much less characterized by techniques of family therapy as much as orientations to working with families. However, a number of what might be described as techniques include:

- reflecting teams and processes
- externalizing the problem and narrative therapy
- interviewing the internalized other

as well as what are better described as therapeutic stances or orientations:

- feminist perspectives
- Just Therapy
- therapy as conversation
- the self of the therapist and resource-focused therapy.

The role of the therapist in the third phase (as in the second phase) continues to be that of a non-expert. Therapy is seen as a collaborative process, involving a co-construction of new ways of seeing problems. This need not necessarily involve new perspectives as such, but can be inspired through validation of family members' difficulties and struggles. Although the therapist and the supervision team are seen as taking a non-expert position, nevertheless it is arguable that there is an expectation that they have sophisticated awareness. Therapy requires a sociological awareness of issues of power: both structural inequalities and the potentially oppressive impact of dominant cultural discourses. Added to this, the therapist is expected to be aware of and to continually monitor their own political dilemmas and prejudices – potentially oppressive assumptions and practices inherent in their privileged position of power and status in relation to the family. This may include their cultural class and gender status and the privileges, as well as assumptions and expectations, of their own professional organizations.

Brief solution-focused therapy

This approach has perhaps some of the closest connections to all three phases of the development of systemic therapy. It has connections with strategic therapies but has evolved to be more collaborative and oriented around ways of facilitating a family's own reshaping of meanings. The overall stance is that of a non-critical position of acceptance and validation. Rather than starting with a framework of looking for and healing pathology, the emphasis is on encouraging families to recognize their

competencies. As such the approach challenges prevailing discourses of 'illness', 'pathology' and 'dysfunction'. This is consistent with a social constructionist approach with its emphasis on how 'problem-saturated' ways of talking about difficulties serves to reinforce and escalate them into problems. By focusing on competence the family is encouraged to change how they talk and think about their difficulties.

> Unlike the accepted view of family therapy that the family unit operates on a principle of a pressure to maintain a homeostatic balance and maintain its boundary, Solution Focused Therapy views change processes as inevitable and constantly occurring. Like the Buddhist view that stability is nothing but an illusion based on a memory of an instant, it views human life as a continuous changing process.
>
> (Berg 1991: 10)

Like strategic approaches, solution-focused approaches are concerned with the patterns of attempted solutions that family members have been employing to attempt to solve their problems but which have been failing. However, they adopt the view that, in fact, families have often been attempting a range of actions which have been solutions.

Focus on solutions, not problems

The emphasis of the approach is to move to a *focus on solutions*, rather than just the problems. For example, parents might describe a child who 'fights all the time' or 'lies all the time'. However, they may also be able, if prompted, to recall some examples of when the child was 'cooperative' and 'honest'. Often these exceptions are seen by the family as insignificant and unimportant. Instead of predominantly attempting to focus on and dissolve the problems, the focus of the therapy is on paying attention to these exceptions and the interactional patterns around them – what mother and father do at these times, how the child starts to be cooperative, where this occurs, the role of other children. From such a detailed exploration of the exceptions some clues may emerge suggesting what the family could 'do more of' in order to encourage the exceptional behaviour. There is a related focus on changes that families may already have started to make prior to commencing therapy – spontaneous recovery. Rather than ignoring such changes, which are said to be common, the therapist draws the family's attention to such changes and works with them to maintain and build on such changes. Where families find it hard to think of exceptions or changes prior to the sessions they can be invited to imagine possible solutions, or solutions that they have seen work in their families of origin and elsewhere.

When asked to report exceptions, families appear to describe two types: deliberate exceptions where they can see that they have done something differently, for example made an effort to discuss their feelings about a problem rather than become drawn into assumptions of bad intentions that lead into patterns of mutual accusations; and incidental or chance exceptions, where things have been different but for external reasons. For example, a couple might have got on better while on holiday, or while the man was ill and vulnerable.

Goal-setting

A central feature of the approach is to collaboratively formulate clear goals with families. These should be described specifically and be relatively concrete so that change and progress are visible to all. One elegant technique that is employed to clarify goals is the 'miracle question'. Families are asked the following question:

> Suppose there is a miracle tonight while you are sleeping and the problem that brought you to the attention of [this service] is solved. Since you are sleeping you do not know that a miracle has happened. What do you suppose you will notice that's different the next morning that will let you know that there has been a miracle overnight?
>
> (Berg 1991: 13)

The aim of this question is to help identify specific behaviours and actions that indicate change, instead of the abstract and potentially unattainable goals that families often articulate, such as wanting to be happy or like a normal family. The process of setting goals is collaborative in that the therapist follows the family's goals.

Overall the approach can be summarized in terms of three rules:

1. *If it ain't broke, don't fix it.* Even the most chronic problems show periods where the troublesome patterns or symptoms are absent or reduced. The therapist needs to have a broad and tolerant view of what 'ain't broke' – what are competencies. These can be built on so that therapy does not become bogged down into attempting to build a utopian family.
2. *Once you know what works, do more of it.* Once exceptions and competencies have been discovered, families are encouraged to do more of these. This can lead to a self-reinforcing cycle of success which will start to replace that of failure, incompetence and desperation.
3. *If it doesn't work, don't do it again; do something different.* Families often become involved in cycles where they cannot see that they have any alternative but to continue to act in the ways that they have, or in fact to do more of the same. For example, a couple who argue may consider that they need to get their point across more forcefully or to withdraw. However, with exploration of the pattern they might notice that this escalation does not occur if they are holding hands at the time or if they listen for longer and do not jump in and interrupt each other continually. This alternative pattern is built on and hopefully will eventually replace the more negative sequence.

The approach assumes that one of the hardest tasks for people in families is to stop behaviours. This tends to imply blame, and there is a tendency for us to become defensive and to attempt to justify our actions. By avoiding this reaction (or resistance) change can occur more easily.

Rigid beliefs – pre-emptive construing

Also underlying the approach can be seen to be an awareness that problems and negative interactional patterns are held in place by constrictive patterns of beliefs. Typically families describe problems in all-or-nothing terms such as always, never, only and nothing, which serve to narrow thinking and produce a kind of 'tunnel vision' (Dallos 1991, 1997). Kelly (1955) termed these pre-emptive constructs, and Beck (1967) in his cognitive theory of depression saw them as rigid and constraining cognitive schemas. Exploring exceptions serves to challenge these rigid beliefs and allows some new ways of seeing the relationships and the problems (Eron and Lund 1993). From these new perceptions it is possible to generate further new solutions or exceptions. Interestingly, this idea of exceptions is also evident in the most contemporary approaches, such as White and Epston's (1990) emphasis on 'unique outcomes' or family stories showing exceptions of competence to their dominant stories of incompetence.

Reflecting teams

One of the ways that attempts have been made to avoid these contradictions is by the use of reflecting teams (Andersen 1987). Instead of consulting in relative secret with an anonymous and potentially oppressive supervision team, the discussions between the therapist and the team are held openly in front of the family. Arguably in this way they are not simply imposing interventions, including new beliefs and meanings, on families, but are sharing their thoughts and concerns with them. Through the team's discussion the family is invited to consider alternative stories, explanations and attributions regarding their lives together. At times the reflecting team may disagree and debate different possible explanations or ideas among themselves. This may allow different family members who are holding opposing views to feel understood and perhaps enable them to move on to more constructive stories. Importantly, the reflecting team enables family members to hear and perhaps internalize a different conversation rather than simply different explanations. By being able to internalize different conversations they are perhaps, in Bateson's terms, 'learning to learn' or being encouraged to become more creative. The therapy thereby becomes less concerned with content and is less in danger of becoming marooned in attempts to offer families a 'better' view or story.

Some therapists (White 1995) also engage in more or less open discussion of political issues, such as the oppressive nature of discourses of mental health, and assist family members to resist through 'externalizing' their problems. Instead of viewing problems as due to their personal failings, people are encouraged to resist, with the therapist's assistance, the dilemmas and contradictions contained, for example, in dominant notions of mental health (unemotionality, self-sufficiency, non-vulnerability, independence, aggressiveness, stability, and so on).

Narrative therapies

> Experience is not what happens to you. It is what you do with what happens to you.
>
> (Aldous Huxley)

The meanings that people give to events serve to explain but also to shape and con strain choices about what are seen to be possible courses of action. Narrative therapie recognize the natural ability that people have to possess, to generate and evolve ne narratives and stories to make sense of their experiences. In doing this we draw o culturally shared narratives or ways of interpreting events and also our own famil traditions (White and Epston 1990; Freeman et al. 1997). There is less of a spl between therapeutic and natural everyday activities which produce change. Bot therapeutic and natural change are seen to centre on conversation; there is not seen t be a fundamental difference in how change occurs naturally and therapeutically. It i suggested that, for example, the natural process of change involves the development c personal accounts of narratives which make sense of experience. However, the reac tions of others, especially family members, to each person's account-making are cen tral (Harvey 1992). Validation and confirmation of these attempts is seen as essentia to change and development. Similarly, therapy is seen as a mutually validating conver sation from which change can occur. Specifically, therapy is seen to consist not just o offering new perceptions and insights but also of the processes of reflection – th nature of the conversation, the way issues are considered and how questions are raise and answered. Therapy can in a sense appear to be 'just talking', though in fact it i these processes of reflection which are being stimulated and which for many familie have become extremely difficult, being disrupted by conflicts and anxieties. (O course, when 'just talking' and 'just therapy' are taken to mean talking about justic and acting justly, no credible disqualification can be made.) Perhaps one of the mos significant techniques to emerge is the reflecting team (Andersen 1990). The discus sions in front of a family offer not only some new stories but also an opportunity t hear different ways of talking about their situation – a different conversational process

> Narrative therapy employs a linguistic practice called externalization, which separates persons from problems. Separating the problem from the person in ar externalizing conversation relieves the pressure of blame and defensiveness Instead of being defined as inherently *being* a problem, a young person can now have a *relationship* with the externalized problem.
>
> (Freeman et al. 1997: xv; emphases added)

Externalizing problems

White and Epston (1990) suggest that problems are derived from the internalization of oppressive 'problem-saturated' ways of seeing ourselves. Part of the process of problem formation and maintenance is a process of internalization so that difficulties are seen in terms of individual or family 'faults', something deficient in individual personalities and their relationships:

> 'Externalising' is an approach to therapy that encourages persons to objectify and, at times, to personify the problems that they experience as oppressive. In this process the problem becomes a separate entity and thus external to the person or relationship that was ascribed as the problem.
>
> (White and Epston 1990: 38)

The techniques for doing this include treating or speaking about the problem as an object or entity outside of the person or the family. As an example they cite how a person supposedly suffering from schizophrenia may be encouraged to resist the all-embracing, 'totalizing' nature of such a definition of their identity by discussing how she could combat or resist the 'voices' which were harassing her. Discussions may focus on some successful instances of how she had been able to 'defy the voices' influence'. White and Epston's approach appears to have the effect of reducing the all-pervasive nature of the labelling associated with problems. Instead of discussing problems with a totalizing narrative in which they totally encapsulate the person so that the symptoms become the defining part of their identity or their relationships (for example, Jim *is a* schizophrenic, or Debbie *is an* anorexic) they can be identified as just one part of their identity. This approach also fits with the increasing attempts to define problems more specifically in terms of profiles of competencies and deficiencies (Boyle 1990). Therapeutic discussion invites people to look at the ways that they may have been 'conscripted' into pathological identities. One part of this can be to explore how they have come to enforce the oppression inherent in such labels on themselves by engaging in self-criticism, self-blame and self-accusations. A related aspect is to explore with family members how they may be imposing these on each other and also conscripting the whole family into a pathological identity – that they are a pathogenic or a 'problem family'.

Externalizing problems is not so much a technique as an orientation or philosophy of therapy. Rather than regarding problems as inherently personal and a central part of the person, they are seen as unwanted invasions which spoil the nature of experience and can promote a sense of failure and inadequacy. In externalizing problems the therapist proceeds not so much by simply identifying this process but by raising questions which invite the person and family members to explore it and to create ways of resisting it. For example, Paul, aged 7, was constantly and apparently uncontrollably soiling himself. Through playful conversations with the therapist, he coined a name for the problem – 'sneaky poo'. Subsequently he explored how and where 'sneaky poo' caught him; for example, he said that he was most likely to be caught when he was distracted – playing or on his computer: 'I think how I tricked him was when I rushed to the toilet, he thought I was still standing there playing' (Freeman et al. 1997: 100). Discussions ensued about the power of mind Paul possessed which enabled him to gather knowledge about the deceptive tactics of 'sneaky poo' and find ways to resist and outwit it.

Writing

In addition, therapy can involve the use of various forms of writing, such as letters from family members to each other, autobiographical accounts, stories, and so on, to facilitate the ability to engage in internal dialogues and reflecting processes (Dallos 1997; Papp and Imber-Black 1996). The use of writing is seen to have a range of functions. To start with it is an activity which carries high status in many societies, and encouraging clients to be able to express themselves in a written form can be seen as empowering. Writing can also encourage the development of reflection and 'internal dialogues' since we can continue to engage with – to have a conversation

with – something that we have previously written. For family members it can als serve to help avoid the compelling patterns of mutual attack and blaming that may b initiated when they start to discuss issues (see the Introduction). Writing to each oth may enable a full and uninterrupted statement of their thoughts and feelings abou each other. Communication in written form can also enable a more considered an less immediate, reflex emotional reaction than speech. For example, the therapist ma write to a family or some members to share her thoughts before a session. The famil has time to consider her written words carefully and may come to the next sessio with some clear ideas which can facilitate a collaborative process of creating some ne narratives.

Feminist therapies

Feminist practitioners have offered major contributions to defining a form of therap that attends to the individual, the relationship and the wider social context. William and Watson (1988) supply us with three central principles in the growth and deve opment of feminist practice:

1 Commitment to equality within therapy – therapy characterized by
   - a demystified and explicit therapy process
   - a demystified therapist
   - strengthened clients' rights in therapy
   - the client as expert about his or her life
   - the therapist's use of power minimized
   - client and therapist having equal worth
   - temporary power inequalities.
2 Commitment to bringing the social context into therapy – to working explicitly with women's experiences of sexual and other social inequalities.
3 Commitment to power redistribution within society – to political, economic and social equality between the sexes.

An influential example of the application of a social constructionist perspective has been the analysis of power and gender relations in families (Goldner 1991; Hare-Mustin 1991). This reveals all aspects of family life – from the daily routines to the most profound experiences – to be shaped by culturally shared discourses of gender. Work with families where there has been violence between couples reveals that, rather than being deviant, these relationships may more accurately be seen as embodying *in extremis* the dominant assumptions in society about relations between the genders. The men seem to be caught in attempts to establish a culturally sanctioned view of themselves as dominant, in control and invulnerable and the women as nurturing, sensitive, responsive to and needing others. Though not excusing or encouraging a denial of responsibility for the violent partners, the feminist systemic perspectives emphasize the processes of unconscious internalization by men and women of these

dominant discourses of gender which shape their 'personal' beliefs and narratives. These filter our perceptions of self and others, and shape what kind of relationships we expect and attempt to create. When there is a rift between these expectations, then frustrating attempts to coerce others to fit into the prescribed roles may lead to threats and ultimately to violence (mainly by men). Women too may in some cases stay in such relationships predominantly because of their socialization and induction into ideas, such as that men are naturally more aggressive, women more nurturing, and most importantly that the violence is an indication of their failure to manage the relationship. The previously dominant view of the family as being women's domain carries with it the responsibility for managing everyone's feelings, including their anger.

Power and the construction of reality

Knowledge and power are seen to be inextricably intertwined, and a prime aspect of this is the rise of influence of scientific thought, medicine, technology, economic analyses, and so on. These forms of knowledge make claims to 'objectivity', that is, to be fundamentally true; a good example here is the idea of the organic, 'scientifically verified' nature of psychotic disorders. Access to these bases of knowledge is regulated; for example, the selection processes for training for medicine or to gain entry into the higher levels of the political domain where confidential knowledge is guarded. In turn, these knowledges have important implications for practices – what is done. Medicine is a good example, with a wide range of institutions, hospitals, equipment, assessment procedures, legal rights, and so on which can be employed to control what is done to people. However, Foucault clarifies that knowledge or discourses do not simply operate in this fairly straightforward way. Instead, he argues that discourses operate in both positive and negative ways. By positive he does not mean 'good', but that they operate to construct ways of thinking about the world: 'Positive . . . in the sense that power is constitutive or shaping of people's lives . . . in "making up" persons' lives . . . negative . . . contributes a theory of repression' (Foucault 1975, quoted in White and Epston 1990: 20).

Culturally available stories

Foucault proposed, then, that society contains a repertoire of dominant narratives which shape our thinking and experience, how we think about ourselves, our inner conversations and how we interact with each other. Not all stories have equal status. In fact he argues that some are made peripheral or subjugated; examples are narratives which are relegated as historical, no longer relevant, such as attempts to frame Marxist ideas as out of date and no longer applicable to modern society. Also, local or subcultural narratives may be dismissed as naive, simplistic or superficial within the dominant scientific/logical framework. This can apply, for example, to racial differences so that until recently many Third World cultures were referred to as 'primitive' societies. Another example may be the common references to young people's views and enthusiasm for change being labelled as idealistic or unrealistic fantasies, and women's arguments regarded as 'hysterical' or overemotional.

Foucault's ideas point to a view of society as containing a hierarchy of narratives, with some relegated to the periphery: 'There exists a stock of available discourses that are considered appropriate and relevant to the expression or representation of particular aspects of our lived experience' (White and Epston 1990: 27). In contrast to constructivist views, this suggests that narratives and their formation are not simply or predominantly personal. Families do not have an infinite number of ways of viewing events, instead there is a limited array of narratives which have been made available to us through our socialization or immersion in our culture. This sets limits to our thinking and serves to constrain our perceived domain of options or avenues of action. Significantly, this analysis also suggests that people attempt to employ these dominant narratives to fit their experiences. Family members can be seen to have unique patterns of experiences and histories, but they will attempt to select a dominant narrative to embrace these.

A young couple, Julie and Damian, discussing their sexual problems, offers an illustration:

Julie: Is it you get frustrated because you think you should be doing it once a week? . . . I don't . . . we don't sit down with other couples and ask them how often they have intercourse . . . it's only what society says . . . I think he's governed by what things should be, or driven by desire.

Damian: Both . . . not just because I feel we should . . . I've got to feel right . . . I'm not just a machine.

Julie: I think he would do it everyday if I wanted to.

Damian: I don't think so . . . I know deep down that if she wanted sex I would but it's never been tested that there is a limit for me (Foreman and Dallos 1992).

This brief extract reveals several dominant discourses that have been identified as common themes in heterosexual relationships. One of the most common is a biological male sexual drive discourse which suggests that men have a greater physiological need for sexual 'release'. In contrast, this suggests that women have less of a need for sex and are more interested in relationships and emotional intimacy. A more 'modern' or permissive discourse suggests that sex is fun and a good physical activity (like aerobics or jogging) which is essential for good health, and regular sex also helps to cement the relationship. These can be seen to operate in this extract overtly and covertly. Julie suggests that Damian is like other men in needing it and he implies he at least partly agrees with this: 'I don't think so' but 'its never been tested'. Julie says she doesn't feel a need to do it so often, which fits with the discourse that women need it less. She also implies that the permissive discourse, 'what society says', sets norms or expectations which drive Damian but not her. In effect, Damian and Julie can be seen as contemplating alternative explanations or stories of their relationship and sexuality, but this contemplation is constrained by the wider domain of available discourses – the dominant narratives. They can attempt to wander outside the perimeters of this domain but then risk a variety of subjugating processes, such as being seen and seeing themselves as eccentric, weird, odd, deviant or perverted.

An awareness of these discourses does not necessarily inevitably mean that people can easily transcend them. White and Epston (1990: 29) suggest that developing

'resistance' or a subversive position in relation to such discourses is an essential part of therapy:

> In joining with persons to challenge these techniques of power . . . we are inevitably engaged in a political activity . . . (if we do not join with persons to challenge these . . . then we are also engaged in political activity) . . . not a political activity that involves the proposal of an alternative ideology, but one that challenges the techniques that subjugate persons to dominant ideology.

Commentary – feminist orientations

A variety of important critiques and developments in family therapy have been inspired by feminist ideas and included important observations regarding the nature of power and abuse in families. Specifically, it was argued that not all members of a family should be seen as having equal responsibility for the problems, and the adoption of a 'neutral' position by family therapists regarding some kinds of problems, such as abuse, could be seen as condoning such actions. In this section we want to explore feminist orientations not just as a critique of systemic approaches but, most importantly, to draw out some core comparisons and contrasts between structural and strategic approaches, and to prepare the way for a discussion of the second wave of applications in Chapter 4.

Feminist approaches take a wider lens and focus not only on the patterns of interactions in families but also on the wider social context. They argue that families should be seen not simply or predominantly in terms of patterns of interactions between the family members but as shaped by the prevalent ideas in society about family life. They also argue strongly that these ideas are largely based upon patriarchal notions which tend to confer a lower status on the activities and roles of women. Within the family it has been traditionally expected that men should be the 'breadwinners' and women responsible for the nurturance of the children and domestic duties. This was seen to cut both ways in that women's supposed natural qualities, such as greater emotional sensitivity, were seen as fitting them to take care of the children. On the other hand, these emotional qualities are typically undervalued in contrast to the more 'rational' scientific qualities that are seen to be valued in the external world of work, for example. However, it was also argued that this arrangement produces a context in which men are burdened with the felt responsibility for the family's economic well-being and are deprived of the experiences that encourage them to be nurturant or emotionally responsive.

Family therapy which did not address these traditional sex roles and expectations was seen as potentially colluding with or reinforcing them (Urry 1990). Blindness to these issues was highlighted in some of the directives and tasks employed by family therapists. For example, Warner (1980) described how a typical intervention such as asking parents to reverse roles could inadvertently serve to further disempower a woman in a family:

> Arnold was an eight-year-old boy who was soiling himself especially when he was at school or away from home. He came at first with only his mother who was encouraged to bring along the step-father and Arnold's two older sisters for the second interview.
>
> Whenever Arnold was soiled and his mother ordered him to the bathroom to wash himself, Arnold had resisted and gone into a temper tantrum. The step-father had not been involved.
>
> A major change in the family functioning was effected by asking the step-father to take a more active part, and by encouraging the mother to allow this to happen. By the time of the third interview soiling was still occurring but the tantrums were no longer taking place. The step-father was directing Arnold to wash whenever he was soiled and this happened without any fuss.
>
> > . . . a considerable lessening of the soiling was reported. However, it was noticed that the mother appeared depressed . . . A paradoxical type of comment was made by the therapist that with the upheavals of her past life and current worries, it was a wonder that she was not more depressed. All the children were asked to carry minor domestic chores for their mother, for which they were to be financially rewarded.

Though no doubt well-intentioned, this intervention can be seen as not recognizing that men and women in families are expected to play different roles and, importantly, that for women their self-esteem and respect may largely be based on their success in the domestic sphere. Regarding the above example, Urry (1990: 108) suggests that the woman

> is being viewed in a framework of having failed, whilst her husband is presented as the solution of her incompetence. The support she is given by the therapists with their 'paradoxical type of comment' offers some understanding to the woman. However, it falls far short of recognising her strengths and encouraging her competences. This therapy is exemplary in the way it maintains myths of male supremacy and reflects a society organized around financial reward.

This critique embraces both a specific point about systemic therapy as having failed to consider images of family life – how families are viewed in different cultures – and the values and expectations that follow. Related to this, it is argued that there is a reality 'out there' which is independent of the observer. Families can be seen as displaying real structures which contain patterns of inequalities and gender roles. Furthermore, it is argued that these patterns are not simply constructed within families but are shaped by the very real structural and ideological forces in society.

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Skill guides

Consultation

Background

With the recognition of systemic practices as offering core skills for a variety of professional activity, practitioners have increasingly applied skills to non-therapeutic contexts. Most usually this has meant practitioners becoming consultants to one another, other welfare or mental health organizations or commercial organizations.

Relevance and usefulness
For practitioners to be able to appreciate and demonstrate the generic nature of systemic practices is extremely important as an underpinning of the new theoretical paradigm. The development of skills that enable practitioners to be useful in conversation with colleagues in turns helps to develop their own credibility and that of the approaches that they employ.

Exercise
Participants are asked to organize themselves in trios (A, B and C): A takes the role of a representative of an organization in trouble, B takes the role of a consultant and C takes the role of an observer. Using the following format, B explores A's problem:

1 What is the problem?
2 What does the problem enable people in the organization to do/not to do?
3 Which roles and relationships in the organization are affected by 1 and 2?
4 How does 3 represent a dilemma for the organization?
5 How does this pattern of relationships enable the organization to manage change?
6 What are the gains and losses of 5 to A and for the organization?
7 What does 6 enable A and the organization to do and not to do?
8 A, B and C share their experiences and learning.

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Externalizing the problem

Background
An original contribution from narrative therapists Michael White and David Epston, externalization is a sophisticated practice based on the premise that exploring a problem or difficulty as if it were a separate 'something' from the person with the difficulty can promote new agency in previously disempowered clients.

Integral to using this approach is a belief that practitioners can see the client as separate from their problems. Practitioners using this skill need to develop genuine empathy and curiosity about the client's struggle with their symptom as if it were an unwanted visitor in their lives.

Relevance and usefulness
Narrative therapy and practices identify some political implications of the context of therapy, and externalizing conversations help practitioner and client alike to rename the dominant stories in people's lives and thus to empower clients to develop new and different stories about themselves. This 're-authoring' may include clients dissociating themselves from dominant, oppressive discourses in the political, economic, social and therapeutic context.

Skills that enable clients to rediscover their agency for life are invaluable for practitioners but none more so than those (like externalizing conversations) that are embedded in respectful collaborative practices.

Exercise
Participants are asked to organize themselves in trios (A, B and C): A is a person with a difficulty, B is an explorer or investigative reporter and C is an observer.

Part I A selects a difficulty or problem he/she wants help with. B inquires about A's problem to ascertain:

1 The problem's influence in different areas of A's life.
2 The strategies, deceits, techniques and tricks the problem uses to intimidate A.
3 Particular qualities possessed by the problem for undermining A.
4 Problems, aims and goals for A's life.
5 Who supports the problem and its schemes.
6 What destructive actions the problem will resort to in A's life should the problem's dominance in A's life be shortened.

Part II This part involves B interviewing A to ascertain ways in which the externalized problem is incompetent, fails to achieve its goals and can be undermined and hindered.

In addition, B seeks to identify what techniques and strategies have been developed by A to undermine and disqualify the problem, as well as any network of relatives, friends and professionals who A feels are available to help deny the problem's wishes.

Then B summarizes with A the ways in which the problem can be successfully demoralized.

Part III Here A talks about their experiences of Parts I and II, and then B and C discuss their reactions to A's experience as described.

Finally, A, B and C have the opportunity to discuss their learning experiences.

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Collaborative inquiry

Background

As constructivist ideas have permeated the field and discussions about power inequalities between therapists and clients have impinged on practice, more and more attempts have been made to develop collaborative approaches to therapy. Generally collaboration carries with it the idea of more than just lip-service to working 'with' clients and presumes the therapists will seek to create a context for genuine inquiry and exploration from a position of 'not knowing' the reasons for the presence of symptoms.

Relevance and usefulness

Because we all create our own experience, the client is indeed the 'expert' about their own life experiences, and a collaborative non-expert approach by the therapist recognizes this client expertise at the same time as offering an authentic invitation (in response to the client's request for help) to explore unfamiliar and uncharted emotional territory in the hope that useful new possibilities for action will emerge. More than any other therapeutic style, collaborative approaches promote client autonomy while offering a non-invasive experience of interdependence with the therapist during the inquiry (therapy) process.

Exercise

Participants are asked to take one of three positions: explorer, presenter or observer (Figure 3.1).

The explorer is given the following guidelines for a conversation:

1 Keep the inquiry within the parameters of the problem described.
2 Allow yourself to hear multiple and contradictory ideas at the same time.
3 Choose cooperative rather than uncooperative language.
4 Use the same words and language as your conversation partner.
5 Ask new questions which are based on the answers to previous questions.
6 Be a respectful listener, and do not understand too quickly.

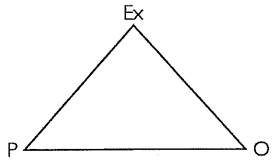

Figure 3.1 Collaborative inquiry triangle

7 Create a conversational context which allows for mutual collaboration in the problem-defining and dissolving process.
8 Keep a conversation going with yourself in your head about what you are hearing from your conversation partner.

Similarly, the observer is offered guidelines for listening and watching the three stages of the conversation:

1 Ask the presenter to describe a problem, complaint or worry. (This can be work related or personal.)
2 Find out how describing the problem in this way creates a problem for the presenter. For example, how does it lead the presenter to organize his or her relationships or behaviour? Map how his or her important relationships are affected by the way he or she (the presenter) is describing their problem. Clarify who are the key players and what they are doing in relation to the problem.
3 Find out what different explanations the presenter holds and others who are affected by the problem. Clarify what effect the different explanations have on the relationships described by the presenter.

After 10 minutes of exploration, the explorer and observer discuss what has interested them in the conversation and speculate about ways forward in the presenter's situation, while the presenter listens without participating.

The presenter is then invited to comment on what they have heard and suggest a direction in which the conversation could usefully develop.

Following another 10 minutes of conversation between the explorer and the presenter, the observer joins for a three-way conversation about the learning and the experience.

Each member of the trio takes a turn in each of the positions.

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Reflecting processes

Background

Since the late 1980s, reflecting team processes have become an important aspect of clinical practice. The method arose originally from the development by Tom Andersen of the reflecting team, in which the family and the behind-the-screen observing therapists switch places during the therapy session so that family members have an opportunity to observe therapists talking about them and then offer the therapists feedback.

The intervention was intended to provide an opportunity for *réflexion* (the French equivalent of reflection), meaning that something heard is taken in, thought

over, and the thought is given back. This way of working aims to promote more egalitarian relationships between clients and therapists.

Relevance and usefulness

It is our belief that in the context of more collaborative and egalitarian relationships, clients are likely to be more receptive to new ideas and therefore to the risks of change.

Authentic feedback from clients and therapists in training who have experienced reflecting processes is unanimously that being able to listen without having to justify, explain or set the record right, while still knowing there will come an opportunity to speak, provides an unusual space in which other new ideas can surface and a different kind of listening takes place. Clients also acknowledge an intense interest in hearing what other people have to say about them.

It is also clear from client feedback that experiencing reflecting processes conveys to clients how much thought and attention is being given to their situation by professionals who simultaneously are perceived as more authentically caring and more professionally useful.

Exercise: reflecting team discussion

1 Participants are asked to get into groups of three, four or five. One person is asked to present a case or situation he or she is feeling stuck with and to say something about the therapy, why he or she feels stuck, and what he or she has done to get 'unstuck'. This should not go on for longer than 10 minutes.

2 The others in the group then discuss the case or situation together, and the presenter becomes an observer, forbidden to speak or even correct any misunderstanding. The group aim to arrive at some systemic understanding of why this person is stuck with this case. This should take about 10 minutes. We often ask the group to use the sequential format described earlier for their discussion.

3 The presenter is then invited to comment on the discussion. He or she usually has views about what seemed accurate or inaccurate, helpful or unhelpful but is asked to refrain from trying to explain his/her views and invited to comment on the discussion he or she has just heard in step 2.

4 Again the group turn to each other to discuss the comments made by the presenter. These comments should be used as information to enable the group to develop further their systemic formulation about the case. They can ask themselves, 'What does it tell us about this system/situation that the presenter has chosen to comment on these particular aspects of our discussion?' This takes about 5 minutes.

5 The presenter can then be invited to comment on this second discussion.

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