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Human Systems as Linguistic Systems: Preliminary and Evolving Ideas about the Implications for Clinical Theory.

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From our earliest practice of family therapy at medical schools, private family therapy institutes, and public agencies, our work with difficult populations that do not respond to current treatment technologies has reminded us of the inadequacies of our theoretical descriptions and the limitations of our expertise. This work has influenced our current, evolving clinical theory as we move from thinking of human systems as social systems defined by social organization (role and structure) to thinking of them as distinguished on the basis of linguistic and communicative markers. Hence, for us, the social unit we work with in therapy is a linguistic system distinguished by those who are "in language" about a problem, rather than by arbitrary andpredetermined concepts of social organization. We call the therapy system a problem-organizing, problem-dis-solving system.

The development of our thinking has been driven over time by our work with chronic treatment failures and court-or agency-mandated cases representing clinical problems involving complex human struggles such as domestic violence, sexual abuse, and chronic illness. Its development has also been driven by our consultation work with, for example, child protective services, women shelters, and adult and juvenile probation agencies; by our training work with the ever-growing variety of students and mental health professionals interested in family therapy; and by our research efforts. Our work has produced challenging conversations with others and among ourselves, conversations that bring forth unsettling issues and that resurrect difficult questions that we, at one time, thought had been answered—for example: What is therapy?; What are the goals of therapy?; How is the target of treatment identified?; What is change?; and What is the role of the therapist?

CURRENT FOUNDATIONAL PREMISES

In our efforts to bring new answers to these troubling questions, and in our efforts to create new options for ways of thinking about human systems, about the problems they present, and about our capacity to work with them, we draw from and expand upon five main premises:

1. Human systems are language-generating and, simultaneously, meaning-generating systems. Communication and discourse define social organization; that is, a sociocultural system is the product of social communication rather than communication being a product of organization. Hence, any human system is a linguistic or communicative system. The *therapeutic system is a linguistic system.*
2. Meaning and understanding are socially and intersubjectively constructed. By intersubjective, we refer to an evolving state of affairs in which two or more people agree (understand) that they are experiencing the same event in the same way. Meaning and understanding involve this intersubjective experience. However, it is understood that agreement is fragile and continually open to renegotiation and dispute. We do not arrive at or have meaning and understanding until we take communicative action, that is, engage in some meaning-generating discourse or dialogue within a system for which the communication has relevance. *A therapeutic system is a system for which the communication has a relevance specific to itself.*
3. Any system in therapy is one that has coalesced around some "problem"—the relevance—and will be engaged in evolving language and meaning specific to itself, specific to its organization and specific to its dis-solution around "the problem." In this sense, the therapy system is a system that is distinguished by "the problem" rather than a social structure that distinguishes "the problem." *The therapeutic system is a problem-organizing, problem-dis-solving system.*
4. Therapy is a linguistic event that takes place in what we call a therapeutic conversation. The therapeutic conversation is a mutual search and exploration through dialogue, a two-way exchange, a crisscrossing of ideas in which new meanings are continually evolving toward the "dis-solving" of problems and, thus, the dissolving of the therapy system and, hence, the *problem-organizing, problem-dis-solving system. Change is the evolution of new meaning through dialogue.*
5. The role of the therapist is that of a master conversational artist—an architect of dialogue—whose expertise is in creating a space for and facilitating a dialogical conversation. *The therapist is a participant-observer and a*

participant-manager of the therapeutic conversation.

We have previously talked about these ideas under the rubric of *problem-determined systems* (2, 3, 29, 30, 32). However, we find that labeling is always a dangerous process, and our use of this term now seems unsatisfactory because it connotes problems as fixed or invariant. On the contrary, we believe that systems are fluid, always in change, never stable, and never finite. That is, the membership of a system should not be thought of as fixed; as the problem definition changes, so can the membership. Nor do we wish to suggest that problems simply erupt into being and demand particular and active solution. Rather, it is the therapist's role to take part in the system's process of creating language and meaning and to keep the dialogue going toward *dis-solving the problem and the dissolving of the system itself.*

Through dialogue, human systems mutually evolve their own language and confirm its meaning. It is this evolutionary, linguistic process that produces the regularities, patterns, and predictabilities that therapists experience as existing independently of their descriptions and that become models for understanding. A *problem-organizing, problem-dis-solving* system is an intellectual construct, just as "family" is a construction. For us, this conceptualization of therapy is a way of thinking that we find useful in our clinical work, in our teaching, and in our research. We also have no doubt but that our current constructions will continue to evolve beyond these understandings.

Just as systems are fluid, so are our ideas about them. Our theories, as well as our practices of therapy are meant as temporary lenses rather than as representations that conform to a social reality. We use our experience with systems in therapy not to confirm our theories but, rather, to energize the search for more useful ways of thinking about, describing, and working with those systems. Theories as well as practices of therapy and family therapy, in our view, are more like ideologies about human behavior than descriptions that conform to social reality. Like all ideologies, they are subject to evolutionary change over time. Therapy can be likened to a process of listening to clients confirm therapists' expectations as, in turn, therapists confirm theirs. It is not a confirmation of the representational reality of the psychotherapeutic theory that is occurring. It is only a conversation that is taking place in the ordinary language of the social times.

Szasz (60) proposes that psychotherapy theory is not a science but, rather, "an ideology about human behavior" and "a cultural phenomenon like a religious philosophy." We would agree with this position and extend it to all (including our own) social-scientific theories. Social science theories are ideologies invented at a moment in time for practical reasons. It is as if all social theory involves a "pre-interpreted" world of meaning. Giddens (25) calls this the "double hermeneutic" of social science and lay language. Social science and the theories of psychotherapy cannot ignore the categories used by people in the practical organization of social life. On the other hand, people assume that the concepts of social science and theories of psychotherapy are elements of their conduct. One's theories of psychotherapy and social science are, fortunately, always changing as the language describing one's social interaction and the conduct of one's life changes through time. This makes for enormous difficulty and increases the impossibility of predicting human behavior. It is impossible for us to change or deny this subject-subject nature of our social and psychotherapeutic theories and practices. Ideas, understandings, theories, and practices will always be evolving and changing over time.

In this article, we introduce and elaborate our current theoretical ideas and some of the implications they have for our clinical theory and practice as these ideas have evolved on this sometimes curious and always challenging journey. We are reminded, however, that although we are fully immersed in these ideas, we do not intend to convey that we believe any of them have a "privileged epistemological status" (56, p. 201), nor do we present them as an alternative theory of family therapy. To the contrary, the path our ideas has taken has led us to question the notion of family therapy itself. To begin, we present our view of the evolution of the field of family therapy during the last 35 years, and of the two contradictory directions that we believe the family therapy field is taking, namely, an emphasis on social systems versus an emphasis on meaning systems.

THE FIRST WAVE

Around the early 1950s, some therapists, simultaneously and separately, were exploring new avenues in their clinical work. This was a time of the rapid expansion of psychodynamic theories having a major focus on the intrapsychic systems of the individual. Within this context, the prevailing view held that symptoms and problems involved only the individual. Psychological relief was achieved through a prolonged process of becoming aware of repressed feelings associated with traumatic historical development. However, some inquisitive clinicians were working with complex clinical populations that were often diagnosed as schizophrenic and delinquent, and with which the available, long-term psychodynamic treatment seemed unable to foster change.

These therapists, representing a wide range of backgrounds and interests, responded to their problem with a pioneering spirit, and a new therapy system evolved: the family. In this group, to mention a few, were Ackerman in New York; Bateson, Jackson, Weakland, Satir, and Haley in Palo Alto; Bowen in Topeka and Washington; Whitaker and Malone in Atlanta; Lidz in Baltimore; Schefflen and Birdwhistle in Philadelphia; Wynne and Singer in Washington and Berkeley; and Goolishian, MacGregor, Serrano, and Ritchie in Galveston. Initially, most were unaware of the work of others, and the field of family therapy did not become a public entity until the late 1950s when presentations were made at meetings of the

American Psychiatric Association and the American Orthopsychiatric Association.

The emerging family therapy field had the excitement and held the promise that is characteristic of the first wave in the development of many new ideas. It was the work of Bateson and his research group in communication and cybernetic theory that gave this new field of therapeutic endeavor its maximum energy. Until the Palo Alto group published their work on the double bind in 1956, most early family work was mired in awkward transformations of psychodynamic theories. The double-bind theory, based in communicative interaction, had the powerful capacity to describe human dilemmas as interactional in nature, and freed the family work from the constraints of individual theory and the language of individual psychology. Haley (31) has described this shift to the family as a "bold conceptual leap."

Family therapy has, no doubt, markedly changed mental health practices, but somehow along the way it has lost most of its early excitement. Many of the early promises of improved outcome and efficiency have not been realized, and in many ways the field does not seem to be far from where it started over 35 years ago. For some clinicians, there seems to be a growing dissatisfaction with family therapy. Minuchin (50 asks, "What is the territory we have conquered?" (p. xi). Dell (17) describes the family therapy field as being in a stagnant condition. "Where are the warriors," wonders Auerswald (5, p. 18-19). We wonder, "What happened to the brand new idea, this bold conceptual leap." Is family therapy the best map for informing the questions therapists ask and for understanding clinical practice? Perhaps, in a Kuhnian (40) sense, the field is in the stage of "normal science" in its development of family systems paradigms, using the new concepts simply as a means of problem solving. Perhaps, and this is our view, the problem is more pervasive and serious. Maybe the leap was not so great after all and this "bold" new concept did not differ significantly from the theoretical position it presumed to replace.

It has interested us for some time that psychological problems seemingly appear, change shape, and disappear as therapists' vocabularies and descriptions change. The new challenge, we believe, is in examining therapists' descriptions and, thus, redefining the problems they work with. The "newness" in the early period was the definition of the problem as "the family." Is this still a useful concept, or has the essence of the problem changed over time? If the problem is in the eye of the beholder, has the beholder changed? We suggest that, over time, *the definition of the problem has changed.*

Our interest is in proposing different questions and assumptions, and in developing different vocabularies and descriptions. We are not proposing another family theory or model of therapy, or a set of alternative solutions to the usual problems of the family therapy field. Kuhn (42) comments that proponents of different theories (or different paradigms) speak different languages. Thus, they express different cognitive commitments that are suitable and useful only in different fields. All sciences, disciplines, and professions, however, can survive the paradigm that gave them birth if they continue the conversation and discourse that will result in changing ideas through changing descriptions. Hence, we are simply offering our thoughts about the problems in the field as we experience and define them. We do this in the pioneering spirit that prevailed during the first wave in the hope that we will be forced to converse about, and deal with, an entirely new set of issues as our understanding of our clinical work continues to evolve.

TWO DIRECTIONS: A DILEMMA IN MEANING

In our opinion, the field of family therapy is now moving (continuing a conversation) in two opposing directions concerning the understanding of human systems, the problems they present, and how therapists might more usefully understand and work with them. The first direction appears to be an extension of the underlying assumptions of the traditional and prevailing paradigm in the social sciences. This direction derives meaning and understanding from observing patterns of social organization such as structure and role. For example, family therapists have moved from the individual to the context (family) and from the family to the context of the larger social system. Within this perspective, social systems can be understood as having meaning derived from observed patterns of social organization.

The second direction evident in the family field is based on the proposition that systems can be described as existing only in language and communicative action. Within this view, organization and structure are the evolving results of communicative exchange, and, therefore, are locally determined through dialogical exchange. This position does not seek universal or normative social parameters in describing social organization. On the contrary, the stochastic complexities labeled and defined as social systems are a result of the continuing struggle toward understanding that occurs between interacting and communicating persons. Meaning and social systems are created in and through dialogue.

Meaning Derived from Patterns of Social Organization

In this prevailing view (or conversation), human systems are seen as sociocultural systems organized according to role and structure, and as characterized by stability, hierarchy, power, and control. That is, sociocultural systems are defined and maintained by social organization through social role and social structure. This general social theory, on which we believe most psychotherapy theories are based, has been well described by Parsons (51-54) in his application of cybernetic concepts to social theory. In this Parsonian perspective, systems are viewed as being cybernetically layered. Order and stability are hierarchically and teleologically related to control from above—to fulfilling the requirements of the total system. For a system to maintain its stability, the relation between the components of the system and the processes that go

on within it (and between the components and their context) must be such that the structure of the system and its components remain unchanged. Homeostasis and permanence are the prevailing conditions.

This view of systems can be likened to an "onion theory" (3, 29). Each system is like a layer of the onion that is encircled by another layer. Each layer of the social onion is subordinate to the layer above and is controlled in the service of the maintenance of social order and stability. Each layer of social organization is in the service of the effectiveness of the superordinate social system. Each layer subsumes and controls subordinate layers in the service of its own requirement—the homeostatic maintenance of social order, stability, and equilibrium. The individual is encircled by the family, the family by the larger system, the larger system by the community, and so on. This imposed restriction of social role and structure acts as a social harness that exists independently of people and provides the order that society calls culture and civilization.

This Parsonian view of social systems implies that problematic behavior, pathology, or deviance within components of a system represent inadequacies in social role and structure. These inadequacies are related to insufficient socialization processes emanating from the hierarchical layer immediately superordinate to the deviant layer. That is, the genesis of problems is placed on the social system superordinate to the one expressing the deviance. This deviance is thought to be the result of an inadequate socialization that results in defective social role and structure. For example, concepts in the family therapy field such as dysfunctional family structure, inadequate generational boundaries, symptom functionality, and inadequate organizational hierarchies are all expressions and extensions of this foundational social theory. Hence, the target of treatment (the social-action unit that the therapist works with) is defined by social structure and role. The task of therapy within this framework is the repair of the social defect (the problem). The descriptive language is that of the therapist as expert in diagnosis and treatment through the knowledge of social systems and their function.

Central to such a social theory of social systems is the notion of empiricism or objective reality. At the heart of this empirical position is a firm commitment to a hypothetical-deductive model of explanation that is based on appeal to external scientific law. Thus, social systems are objectively defined and exist independently of the observer. The observer can only inquire as to the representational adequacy of the language used to describe the system. Knowing how a system should be, therefore, places the observer, the therapist, in the independent position of determining how the system is (pathology/diagnosis) and fixing the system as it should be (normalcy/treatment). All this is according to the therapist's objective descriptions. In the family therapy field, there is an increasing dissatisfaction with the view that social sciences and psychotherapy are to be thought of in the terms of the logical empiricism of the so-called natural sciences (1, 4, 5, 6, 8, 9, 12, 13, 14, 15, 16, 18, 19, 34, 35, 39, 40, 47, 57, 58, 59, 61, 62, 63).

In the remainder of this article, we will expand on a theory of meaning and interpretation as an alternative to prevailing Parsonian social theory, and will contrast the implications of this alternative for clinical theory and practice.

The Domain of Meaning: Human Systems as Linguistic Systems

In this different direction (or conversation) for the field of family therapy, human systems are seen as existing only in the domain of meaning or intersubjective linguistic reality. In the domain of meaning, social systems are communication networks that are distinguished in and by language. That is, they communicate with each other; they are in conversation with each other. This domain of meaning is referred to as a linguistic or a conversational domain (7, 8, 44, 45). The linguistic or conversational domain is the term used to designate the aggregate of language interactions (communicational interactions) of participants engaged in dialogue and conversation. By language, we do not refer to a specific focus on signs, structure, or style. Rather, we refer to the linguistically mediated and contextually relevant meaning that is interactively generated through the medium of words and other communicative action. This generated meaning (understanding) within a particular social context is evolved through the dynamic social process of dialogue and conversation. We live with each other, we think with each other, we work with each other, and we love with each other. All this occurs in language.

We prefer the use of "language," "to be in language," and "languaging" in order to distinguish this process from the current tradition of psycholinguistics. In the psycholinguistic model, meaning and understanding are more thought to be derived from the logic of signs and symbols, from grammatical structure and its logic and separate from its use (49). In our view, humans can be conceptualized as more than simple information-processing systems. We are users of language. We speak, hear, write, and use all of the many expressions and forms of language as part of the general human process of creating and dealing with the realities in which we exist. It is in language that we are able to maintain meaningful human contact with each other and through which we share a reality. To "be in language" is a dynamic, social operation. It is not a simple linguistic activity. Wittgenstein (64) uses the concept of language game to imply this dynamic character of language. We also conceptualize language as a human tool that is put to a specific use and that cannot be understood or have meaning outside of the context of this use. By "being in language," we refer to the process of the social creation of the intersubjective realities that we temporarily share with each other. It is understood that this is not a totally adequate model to understand the full operation of the human use of language. To be in language is, however, a distinctively human process because it is

through language that we are capable of forming the shifting communities of meaning to which we belong and that are for us the intersubjective realities in which we exist.

Humans, then, can be defined as language-generating, meaning-generating systems engaged in an activity that is intersubjective and recursive. Hence, the construction of meaning and understanding, the construction of human systems, is a constantly changing, creative, and dynamic process. This view of human interconnectedness does not rely on a definition of perception and cognition that requires a representational or objective view of reality. Rather, this emerging position has, at its core, the belief that reality is a social construction. We live and take action in a world that we define through our descriptive language in social intercourse with others. To say it somewhat differently, we live and take social action in a multiverse of worlds of description. Maturana and Varela (45) take the position that every human action takes place in language, and also that every act in language brings forth a world created *with others.* According to these authors, we create the objects of our worlds with and through language. In a similar vein, Bateson (7) held that the mental characteristics of a system are immanent in the system as a whole. The mind (meaning) is not in someone's head but, rather, in interaction. Thus, Bateson questioned the concept of an objective reality and the ordinary ways that therapists make sense of the world; he challenged us to keep in mind that, in our observations, it is more familiar and comfortable to select that which confirms our already existing beliefs. Bateson (7) called this new way of thinking about *ideas* an "ecology of minds" or "ecology of ideas.rdquo;

The conceptualization of reality as a multiverse of meanings created in dynamic social exchange and conversation interaction moves us away from concerns about issues of unique truths and into a multi-verse that includes a diversity of conflicting versions of the world (28). Within this framework, there are no "real" external entities, only communicating and languaging human individuals. There is only the process of the constantly evolving reality of language use. Thus, there are no "facts" to be known, no systems to be "understood," and no patterns and regularities to be "discovered." This position demands that we give up the view of humankind as the "knowers" of the essences of nature. In its place is substituted a view of humankind in continuing conversation.

Conversation—language and communicative action—is simply part of the hermeneutic struggle to reach understanding with those with whom we are in contact. Said differently, language does not mirror nature (55); language creates the natures we know. Meaning and understanding do not exist prior to the utterances of language. In this context, understanding does not mean that we ever understand another person. On the contrary, we are able to understand through dialogue only what it is that the other person is saying. This understanding is always in context and never holds over time. In this sense, understanding is always a process "on the way" and never fully achieved. We only understand descriptions and explanations. We do not understand events because, in this view, there is never a single event to describe, and no particular understanding exhausts all the potential infinities of meaning.

In this article, we propose to develop some of the theoretical implications of this position for the field of therapy.

LANGUAGE SYSTEMS AND THERAPY

This emphasis creates an alternative to thinking of social role and structure as existing in some kind of reified and empirical social reality. It construes language and communication as basic to social conduct. Thus, social organization is the product of social communication, rather than communication being a product of organization. This is a different position than that defined by Haley (31) who states that only a change in hierarchy will change communication. Our view is that communication and discourse define social organization and that reality is a product of changing dialogue. This view is similar to that of Maturana and Varela (45) who hold that there is no information exchange (or transmitted information) in communication. On the contrary, they hold that humans say and hear according to the way they are structured, not according to the social organization in which they are embedded. In a slightly different vein, Braten (10) defines a sociocultural system as a "meaning-processing system of interacting participants who maintain and transform the identity of themselves and of their network through a more or less shared understanding of both themselves and the world" (p. 193). He further states that this shared understanding is neither subjective nor objective, but that it is intersubjective, generating the subject-object complimentarity (p. 195). Braten refers to this as a dialogical crossing of perspectives, which he cautions can collapse into a monological perspective under certain conditions. In a mono-perspective, the development of new meaning ceases because one set of all possible sets of ideas dominates and becomes invariant. One must be careful, however, not to confuse a mono-perspective with problems, that is, to think that a mono-perspective is always problematic. It may or may not be.

Human social systems require the linguistic coupling of their components (individuals) such that they can operate with each other as observers in language. Thus, social systems are a constantly changing product of socially communicated realities, and are based in the uncertainties of dialogue and discourse in our continuing struggles to reach agreement. Put another way, language is the substance through which social structure and role are derived.

When we apply this concept clinically, it is sometimes difficult to keep in mind that the systems we work with exist only in our descriptions. These descriptions, from whatever theoretical orientation they are derived, exist only in language. The

systems that we, as therapists, work with are the narratives that evolve through therapeutic conversation. They are the products of interactive linguistic domains of existence. Systems, then, do not exist in an external, or unilaterally determined, social reality; systems exist in languaged interaction and in the rhetoric and metaphorical narrative of our theories.

Therapy Systems as Problem-Organizing, Problem Dis-solving Systems

In defining the target of treatment as encompassing a social action system defined on the basis of communicative interaction, it becomes necessary to look beyond systems that are predefined on the basis of social definition, and look to those who are in active linguistic coupling. The system to be treated includes those who are in a languaged context about a problem. Such a system may be smaller than a family; may be a family; may be larger than a family; or may consist of relative strangers. It is the people who are in a problem context, the people who "language" about what they call a problem, the people who comprise the social system that is the target of treatment. Languaging within the domain of a problem distinguishes the system; the system does not distinguish the problem. To put this differently, systems do not make problems; languaging about problems makes systems. We think of such a defined system as a *problem-organizing, problem-dis-solving system.* It is a social-action system that is organized around languaging about issues that concern and alarm those who comprise the system.

Because problem-organizing systems exist in language, they take no account of the boundaries punctuated by social structure and role. In this framework, the object of treatment is no longer defined as individual, family, larger system, and so on. This is not to say that we do not see individuals or families in our offices. But, rather, when we do, our thinking is punctuated in terms of the communicative networks (the related actors) and dialogical exchanges that define the problem, and is not punctuated in terms of predetermined social structure. The concept of problem-organizing system, however, is not meant to invoke another kind of objectified pathology; it is meant to imply a different definition of system parameters.

Problems, as alarmed objection, are a form of co-evolved meaning that exists in ongoing dialogical communication. In dialogue, new meaning is under constant evolution and no "problem" will exist forever. In time all problems will dis-solve. That is, all problems entail an increasing or shrinking number of people and their involvement, and all problems involve a continually changing meaning, dependent on who is in relevant communicative action with whom at any moment in time. The actors in a problem system will change over time and, as the conversation changes, so does the defined or described problem with which they struggle. That is, problems and the systems organized by them are not fixed entities existing over time until they are resolved or repaired. Problems and problem-organizing systems are changed and reinterpreted just as often, and just as rapidly, as the other narratives around which we organize meaning and social exchange.

We live with each other in a world of conversational narrative, and we understand ourselves and each other through changing stories and self-descriptions. Along with Wittgenstein (64), we would emphasize that meaning (the co-created narratives and thematic networks through which we organize and define ourselves and others) is derived from the intersubjective and communicative uses to which meaning is put. Meaning and problems are not simple derivatives of formal structure and definition. As Hoffman (35) has indicated, we no longer think of problems as "in" the family, or in any other spatially and socially defined unit. Problems are in the intersubjective minds of all who are in active communicative exchange and, as such, are themselves always changing.

SOME IMPLICATIONS FOR CLINICAL THEORY

How we think about therapy is of prime importance to the way we conduct our business as therapists. To think about human systems as existing in a linguistic domain (the world of meaning, understanding, and narrative) presents a major challenge to the theories and practices based in a Parsonian sociology. Many of the implications that language systems concepts have for therapy are quite contradictory to clinical practices based on a social theory in which meaning is assigned to interaction and in which systems and ideas are objectified on the basis of social structure. Our intent is not to dismiss or abandon current family theory and therapy. Rather, we suggest that some of the accepted concepts in traditional theory and practice constrain our creative abilities to think and work effectively.

We will elaborate on how the idea of human systems as meaning and language systems translates to the therapy system around the interrelated notions of therapy and change, therapist role, and problem definition.

Therapy and Change

The philosopher Gadamer often cites a phrase from Hans Lipps (43) who states that any linguistic account carries with it a "circle of the unexpressed." Gadamer (21) calls this the "infinity of the unsaid." What is meant by this is that no communicative account, no word, is complete, clear, and univocal. All carry unspoken meanings and possible new interpretations that require expression and articulation. This is not to imply that the original linguistic account was deficient but, rather, that all communicative actions are an infinite source of possible new expression and meaning. Thus, the subject and content of all dialogue and discourse is open to evolutionary change in meaning. Knowledge advances through this

process of looking for the "unsaid." As Gadamer implies, The characteristics of all dialogical conversation is that participants open themselves to others and accept their point of view as being worthy of consideration. It is through this process that we, in language, get inside each other to the extent that we understand not the individual, but what he or she is saying. It is this characteristic of dialogue that makes and continues change.

We believe that therapy is a process of expanding and saying the "unsaid"—the development, through dialogue, of new themes and narratives and, actually, the creation of new histories. Therapy relies on the infinite resources of the "not-yet-said" in the narratives around which we organize ourselves in our conduct with each other. This resource is in the "circle of the unexpressed." The realization of change requires communicative action, dialogue, and discourse.

This resource for change, the *not-yet-said,* is not "in" the unconscious or any other psychic structure. This resource is not "in" the cell or the biological structure, nor is it "in" a social structure such as the family. This resource is in the "circle of the unexpressed." This resource, this capacity for change, is in the ability we have "to be in language" with each other and, in language, always to develop new themes, new narratives, and new stories. Through this process, we co-create and co-develop the systemic realities around which we have meaning for each other, and through which we continually reorganize our mutual living and our self-descriptions. Change requires communicative action, dialogue, and discourse. For therapy, what is required is the maintenance of conversation, such that the logic of the content of a problem system is doggedly explored through inquiry. In carrying out this exploration, other descriptions and meanings will emerge that are no longer labeled in language as a "problem." This is the process of change.

Therapy is a linguistic activity in which being in conversation about a problem is a process of developing new meanings and understandings. The goal of therapy is to participate in a conversation that continually loosens and opens up, rather than constricts and closes down. Through therapeutic conversation, fixed meanings and behaviors (the sense people make of things and their actions) are given room, broadened, shifted, and changed. There is no other required outcome.

From Ordinary to Therapeutic Conversation

Conversation and dialogue always rest on a fragile set of conditions. These include issues of mutual respect and understanding, a willingness to listen and test one's opinions and prejudices, and a mutual seeking of the rightness of what is said. The meaning that derives from conversation is always dependent on a number of evolving issues, including:

- the occasion for the conversation
- the relationship of the participants to each other
- what each knows of the situation and intent of the others
- what the participants hope to accomplish
- the applicable social and cultural conventions
- the ever-changing intended meanings of the participants

Because of this fluidity, meaning and understanding in dialogue and conversation are always an interpretive activity and always in flux and change. There are no fixed and uniquely correct situational (contextual) interpretations to guide a conversation. All meaning, understanding, and interpretation is inherently negotiable and tentative. Likewise, there are no fixed meanings transferred in conversation. All participants in a conversation bring with them totally different worlds and are continually shaping these worlds in the process of dialogue. This reshaping requires the intimacy of conversation—that we remain in continuing language contact with each other. Conceptualized in this fashion, language and conversation are always a dynamic social activity, and meaning is always, in some measure, indeterminate.

The therapeutic conversation is basically no different from any other. It is, at its core, the basic process of people trying to understand each other. In a therapeutic conversation, the therapist is constantly touching base with all members of the *problem-organizing* system. It is in this shifting conversation and in the constant exploration of the logic of the various descriptions of the problem system that we co-evolve the "not-yet-said." The members of the problem system relate to the logic of the system in different ways and with different value investments, yet all must have a chance to discourse and change, at their own speed and in their own way. *In dialogue nothing remains the same. Change in therapy is no more than changing meaning derived through dialogue and conversation.*

From the initial contact and throughout the course of interviews, the therapist must make choices and decisions about what to talk about. What is said does not simply arise out of the blue. The therapist, like everyone in conversational exchange, is always looking for intended meaning and creatively synthesizing information, understanding, and meaning. In doing this, the therapist takes cues and uses clues from the clients. How does a therapist choose what to respond to and in what way? How does a therapist know what questions to ask? The following are some general and interrelated elements central to a therapeutic conversation.

1. *The therapist keeps inquiry within the parameters of the problem as described by the clients.* This is accomplished in a way that expands options for new meaning. These new meanings must be such that they respect all members of the

problem-organizing system, including the therapist. Toward this end, the therapist stays close to the understanding of the moment, works within it, and slowly eases outside of that parameter. As Bateson (7) has indicated, making room for the familiar leads to room for the novel.

2. *The therapist entertains multiple and contradictory ideas simultaneously.* Equal enthusiastic interest in and respect for all ideas is demonstrated. The therapist takes whatever is said seriously and accords mutual plausibility to all that is said. Toward this end, the therapist inquires in a way that does not judge the "rightness" or "wrongness" of any one view. Such actions create the opportunity to move the interview in the direction of a mutual inquiry about familiar ideas and, hence, toward the broadening, shifting, and synthetic creation of new narratives, interpretation, and meaning.

3. *The therapist chooses cooperative rather than uncooperative language.* The therapist takes seriously what he or she is told, no matter how astonishing, trivial, or peculiar. Inquiry must show a respect for, not a judgment of what is said. To do so enhances linguistic mobility and moves the interview toward collaborative conversation rather than toward confrontation, competition, polarization, and immobility.

4. *The therapist learns, understands, and converses in the cIient's language* because that language is the metaphor for the client's experiences. The client's words, language, and meaning are what is going on in the client's life. In therapeutic conversation, it is essential that the therapist evolves understanding through the metaphor of the client's experience.

5. *The therapist is a respectful listener who does not understand too quickly (if ever).* The more quickly a therapist understands people, the less opportunity there is for dialogue, and the more opportunity for misunderstanding. Understanding too quickly runs the risk of blocking the development of new meaning (new narrative) for the client and the therapist.

6. *The therapist asks questions, the answers to which require new questions.* That is, the therapist develops the art of asking questions that are not focused on discovering information and collecting data. Questions are not considered interventions, searches for preselected answers, or checking out hypotheses. Questions are the tools of the therapist in a therapeutic conversation, and they are to be guided and informed by the views of the clients so that the conversation is geared toward the maximum production of new information, understanding, meaning, and interpretation. This requires that the therapist take everything seriously, have a good memory, and find a way to pick up on small pieces of conversation later in that interview or in other interviews. This is all part of developing new connectedness. It is the process of carrying on multiple conversations simultaneously such that, over time, new ideas will begin to evolve and make contact with each other. It is in our questions that we display the skill of "worldmaking." Therapist's questions are the springboards for mutual inquiry and discussion.

7. *The therapist takes the responsibility for the creation of a conversational context that allows for mutual collaboration in the problem-defining process.* The therapist does not define the problem or steer the conversation toward a problem definition prejudged by the therapist to be a more useful definition. Nor does the therapist try to move the discussion toward a consensus (or synthesis) problem definition. Instead, the therapist facilitates an elaboration of the multiple realities about the problem in the interest of maximizing the creation of new meaning.

8. *The therapist maintains a dialogical conversation with himself or herself.* That is, the therapist must develop the ability to entertain multiple views even when the participant other is himself or herself. This is necessary in order that not one idea, or any aggregate of ideas, monopolizes thinking. All views and ideas of the therapist are tentative, on the way and subject to change through conversation. Said differently, the therapist is prepared to negotiate and change views just as any other member of the problem system. This is not to say that the therapist cannot have preunderstandings, opinions, and prejudices. We can and do. In a therapeutic conversation, these are opportunities to initiate dialogue, and they are offered in such a way that conversation is continued rather than closed.

We believe that these elements, when combined with the ordinary elements of conversation, will evolve into a therapeutic conversation. A therapeutic conversation is an open conversation in which the focus is in the direction of evolving new understanding of the problems and issues at hand. Therapy and therapeutic conversation require the maintenance of conversation such that the logic(s) of the content of a problem system is doggedly explored through inquiry. In carrying out this exploration, other meanings and descriptions will emerge that are no longer labeled, in language, as a "problem." Put another way, the process of therapy is elaborating on, and remaining in conversation until the problem disappears. It is not as if the problem is elaborated on and then "fixed" by the therapeutic intervention but, rather, that the problem, through language and conversation, evolves new meaning, interpretation, and understanding. Therapeutic conversation is not the process of finding solutions. No solution is found; the problem *dis-solves.* Therapy and therapeutic conversation are processes in which the changing language and meaning of problem definition yield a *dis-solving* of the problem and, therefore, the *dissolving* of the *problem-organizing* system.

Therapist Role

The position and expertise of the therapist from this perspective of therapy and change is twofold: (a) the therapist is *a*

participant observer, and (b) the therapist is a *participant manager of conversation.*

Participant Observer

The problem system is considered one kind of observing system (20) and all members are thought of as participant observers. Hence, the therapist is a member of the problem system and, as a participant observer, is in an egalitarian and nonhierarchical position, as are the other members. As a participant observer, the therapist is not considered to be "meta" to the system being treated. The therapist becomes a member of the problem system, and this position forms as soon as the therapist begins talking with any person(s) about a problem.

This therapist position is collaborative. It is one of mutuality, modesty, and respect for and about people and their ideas. The therapist is "in there" as a learner, cooperating with, attempting to understand, and working within the client's meaning system. Client's ideas, their stories and narratives, are the only available tools we have to keep ourselves and our clients open and flexible to the development of new meaning and understanding. Put another way, this therapist position moves therapy toward a process in which all participants, including the therapist, can be open to change, and in which the meaning and integrity of no one is challenged.

In this framework, the therapist does not enter with an overarching map of psychological and social theory regarding human nature and human difficulties, a map on which to fit the clinical data and, thus, the client. Rather, therapist and client create the maps together—the therapeutic realities. From the initial contact and throughout the therapeutic relationship, the therapist and client are engaged in collaboratively creating descriptions and stories. It is as if the "talking" therapies, much like life itself, are the opportunity to develop and explore new descriptions, themes, and plots around which we organize ourselves with each other.

Put another way, using Rorty's (56) metaphor of the mirror, the therapist is not simply a mirror reflecting more accurate representations of reality for the clients' benefit. Therapy is not a process of mirror polishing whereby the therapist inspects, repairs, and polishes defective mirrors so that the client can attain more accurate representations of the "real" psychological world.

Participant Manager of Conversation

The therapist is a master conversational artist, an architect of dialogue whose expertise is creating and maintaining a dialogical conversation. This requires creating a space for and facilitating a conversation such that it remains in a dialogic domain. In such a process, the opportunity for communication regarding the "problem" is maximized; new descriptions arise, new meanings are generated, and, therefore, new social organization will occur around different narratives. This dialogical space can be likened to the imaginary "Fifth Province" in Irish mythology where members of the four provinces, "[c]aught in webs of conflict and competition from which there appeared no exit," would meet to *disposition* (46, p. 189). To describe this fifth province, McCarthy and Byrne (46) quote Hederman and Kearney (33):

> It was a place where even the most ordinary things can be seen in an unusual light. There must be a neutral ground where things can detach themselves from all partisan and prejudiced connection and show themselves for what they really are .... This province, this place, this centre is not a political or geographical position, it is more like a disposition. [pp. 10-11]

As a participant manager of conversation, the therapist is only "a part of a circular interactive system" (7, p. 361) and process. The therapist does not control the interview by influencing the conversation toward a particular direction in the sense of content or outcome, nor is the therapist responsible for the direction of change. The therapist is only responsible for creating a space in which a dialogical conversation can occur and for continually steering the conversation in a dialogical direction. Braten (10, 11) describes this process as intersubjective. By this he means a dialogue in which all participants can make room for the creativity and consciousness of each other.

The creating of a space for, and the facilitation of a dialogical conversation is central to the therapist positioning described above. This position is more than one of simple neutrality. It is one of multi-partiality, taking all sides and working within all views simultaneously. As therapists, we all hold values, biases, and prejudices; and we all have opinions about people and about how all of us should or should not conduct our lives. Such prejudgments are simply there. We cannot be blank screens. We think of these prejudgments as opportunities. That is, they are the energy to spark curiosity and the drive to explore other ideas. To be able to take a multi-partial position requires that we are willing and ready to risk entertaining alternative opinions and meanings (26). That is, therapists must be as able to let go of old meanings just as we expect our clients to be able to do so. Only by risking change are we able to engage in the mutual conversation and dialogue that permit new understanding to develop.

In this process the therapist changes. For us, the willingness to risk and undergo change is the essence of therapeutic ethics. We would hold that the only person the therapist changes in the therapy consultation is himself or herself. This

position is in contrast to the two prevailing views of ethics. The first requires that the therapist take a strong stand and take action based on his or her ethics. For example, the idea of "empowering" clients is an expression of this view. The second view requires that the therapist's ethics must be shielded and that he or she must serve as a blank screen, that is, the therapist does not take a position.

We, as therapists, are always taking positions. As therapists we are never void of values and always operate on the basis of these views. These prejudices, however, are not imposed on clients. Rather, therapist and client in dialogue with one another are always acting on and reflecting their ideologies, their values, and their views. To be in dialogue is to attempt to understand others and to involve oneself in the coevolution of understanding and meaning. This implies an openness to the "rightness," the logic, and the validity of the ideologies, values, and views of our clients, and the willingness to negotiate the validity of our own.

For us, this is neutrality. Neutrality is not *not* having a position but, rather, always evolving new interpretive positions as a result of dialogical communicative action and the resulting, changing realities. Therapeutic conversation and this kind of neutrality requires a willingness to put one's prejudices on the line and to take seriously the claims to validity raised by our clients (26), and, thus, to risk having one's own views exposed, challenged, and changed. The integrity of no one is challenged.

Diagnosis and Problem Definition

The use of diagnosis and diagnostic categories enjoys a long history in the field of mental health. For many, diagnosis is considered to be central to the field of psychotherapy. We often hear questions like "How do you treat schizophrenia?" or "How do you treat sexual abuse?" The theoretical and Parsonian assumption in such questions is that there is a problem that exists in some common pattern or redundancy associated with particular categories of problems related to some particular kind of social structure. As clinicians, we are trained to know what those patterns and structures look like. We are trained to recognize them and to diagnose them. It is our belief, however, that, in the end, we arrive at only our own descriptions and explanations of the problem. That is, the therapist reaches a diagnosis that is based on his or her private observations and experiences of the client's behavior. These private observations are the so-called objective criteria that the therapist then fits onto a diagnostic or normative map. Hence, as observer and perceiver, the therapist is thought to act as a "rather passive recipient and integrator of available information" (5, p. 42). In this widely held and traditional view, the therapist has the special status of an expert with access to information and knowledge regarding the client (47, 56).

This familiar notion of diagnosis embraces the idea that there is an objective problem, and that the therapist can arrive at an objective description of that problem. This description includes questions regarding what is wrong (for example, names the pathology, the defect, or the deficit); what a normal system is (healthy individual, family, or larger system); and what action must be taken to cure the problem (that is, what strategies and interventions will move this system from the pathological to the healthy). Objective description or diagnosis in this Parsonian perspective is linear and interventionist. This traditional position characterizes most psychotherapies, whether they are oriented to the individual, group, family, or larger system.

A shift from social structure to the linguistic domain, as a way of describing and understanding problems, moves us from the notion of empirical objectivity and representational language. It is not easy, however, to give up the notion that there is a reality out there, that there really are data waiting to be discovered. It is also not easy to give up the notion that our words do not reflect and represent such a reality. Golann (27), for example, complains that the current shift to a relativist (constructivist) position in family theory moves too quickly away from the representation of family structure. Some of this concern seems embedded in a kind of nihilistic fear. How will we know what to do if we give up our empirical positions and call into question our familiar processes of diagnosis? Yet, we cannot escape the conclusion that our traditional, diagnostic technologies are based on a categorizing of commonalities across problems and related social structures. This does not seem to us to be an adequate description for working with systems defined as existing only in the shifting sands of language, meaning, and narrative. Our view holds that each observation, each problem description, each understanding, each treatment is unique to the communicating realities in which we participate. These realities are always in flux and never stay the same.

One of the early challengers of the notions of objectivity and dualism regarding diagnosis in the family therapy field was Bateson (7). He challenged therapists to give up many of their typical diagnostic activities. Other social scientists outside the field of family therapy have also addressed this same concern about objective description and dualism (20, 23, 24, 26). Gergen (22), for example, gives a fascinating example of the dilemma of what he calls behavioral identification—diagnosis. He begins with the simple dilemma: "If I see my good friends Ross and Laura approach each other at a social gathering, and Ross reaches out and momentarily touches Laura's hair, precisely what have I observed?" (p. 60). Through a discussion about information in a retrospective context (sequence of events occurring prior to the action in question) and in an emerging context (relevant events following the action in question), he takes the reader on a step-by-step quest for the answer which leads them to three propositions: (a) the identification of any given action is subject to infinite revision; (b)

the anchor point for any given identification relies on a network of interdependent and continuously modifiable interpretations; and (c) any given action is subject to multiple identifications, the relative superiority of which is problematic (pp. 62-64). Jones (38), in a similar vein, suggests that we often find what we expect in our psychological research (we would add our diagnostic search). He claims that this self-confirmation is a result of processing information in selective ways and, more importantly, a result of our expectancies, which actively causes us to elicit those behaviors that confirm our theories.

For example, it is not surprising that family therapists when called upon to role-play a family will, almost without exception, invent a family that exemplifies the theoretical position of structural family therapy. Do these families exist or do therapists simply bring them forth by their theoretical expectancies? It is our position that the latter is more likely the case. For us, this exemplifies the notion that observing behaviors (behavioral identification) in the therapy room tells the therapist little, and that more information is not necessarily better. We are, therefore, compelled to maintain doubt and uncertainty about our observations and to hold more interest in the multiple meanings that people's observations and experiences have for them. In problem-organizing systems theory, diagnosis is little more than talking with our clients about the problems as they, the clients, have identified them.

Most therapists would quickly agree that their values and biases influence what they observe and that their information processing is selective. Yet few would subscribe to the notion that their expectancies (descriptive theories) determine client behavior and all other information that is supposedly "discovered." As therapists, our tendency is to overlook our active participation in the behavioral confirmation of our predetermined hypotheses and diagnoses. Equally important is the fact that clients also bring biases and values that influence their expectations of the therapist and of therapy. Through these biases they filter the actions of the therapist and find confirmation for their own expectancies. In our view, the information that the client presents, as well as the information that develops in the therapy process, is a product of social exchange. Giddens (25) referred to this process of mutual confirmation and evolution in language as the "double hermeneutic" of the social sciences. The burden of problem definition or diagnosis is not a matter of therapist observation, but more a matter of conversation and communicative agreement. That is, both therapists and clients jointly participate in the creation of the diagnosis, or what we prefer to call the problem definition(s).

"Diagnosis," in this view, is little more than a continuing conversation with all who are sharing a mutual concern and alarm. This concern does not mandate consensus; consensus regarding the nature of a problem is rarely achieved. Diagnosis takes place in a conversation that will produce constantly evolving and changing stories and meaning. Therefore, problems, their descriptions, and those who describe and define them are always in continuing flux. The conversations that we engage in, as we struggle to live in agreement with each other, are like fairy tales and stories. They are capable of infinite revision and reinterpretation. Problems, in this linguistic metaphor, can be thought of as "lumps of meaning" in a batter whose consistency is always changing through dialogue.

Collaborative Problem Definition

As we have moved away from the notion that therapists possess an expert knowledge that allows them to diagnose the onto-logical reality of a system or to define the problem, we have moved in the direction of a collaborative problem definition that begins with our curiosity about what it is that people are concerned about, who is concerned, and who are the performers that make up the communicating system. For us, *a problem is concerned or alarmed objection about something or somebody that someone is trying to do something about.* A problem exists only if there is communicative action—complaint or concern. A problem exists only if it is described and understood by people in concerned or alarmed communication with each other. It is a statement, a linguistic position that someone takes. If there is no languaged concern or complaint, there is no problem.

Toward this end, we begin the therapeutic process by talking within the client's definition of the problem. We want to know all the views of all of the members of the problem system regarding what they think the problem is—their diagnoses, their hypotheses, and their theories. In talking about the problem, the therapist and the client are in the process of creating the problem(s) they will work on in therapy. The therapist does not define the problem, nor does the therapist steer the discussion toward a problem definition that is prejudged by the therapist to be a more useful definition. By engaging in the therapeutic conversation, the therapist becomes a member of the problem system and, as such, becomes as equally and actively responsible for the co-creation of the problem definitions and their remedies as is the client.

Our responsibility as therapists, as participant managers of therapeutic conversation, is in the coevolution of a conversational context that allows for a problem-defining process. This is a mutual process; the therapist is not its director. This is similar to Kelly's (41) views of the therapist's role, which he conceptualized as the therapist guiding the client to elaborate on his or her view of the problem. Kelly also believed that this was a crucial step in the therapist's attempt to understand the client's construct system. It is impossible ever to understand (to diagnose) anybody. All we can ever hope to understand is what it is that others say to us. For Kelly, personal constructs are socially constructed, guiding maps around which behaviors are organized. Our view is that these "maps" are intersubjective and include the therapist.

Problem descriptions must be *workable.* By workable, we do not mean to imply a selectivity toward a particular goal or a directionality, but, rather, that the process of elaborating on descriptions must move in the direction of opening up rather than closing down, mobilizing rather than immobilizing. To be workable, the problem descriptions have to be understandable and make sense to all engaged in the problem system. Problem descriptions must enable positions of mutual respect to be maintained. The elaboration of problems has to be such that everybody in the problem system (including the therapist) can participate in the changing meaning. Put another way, a therapeutic reality must be created that is "*psychologically safe*" for everyone. It is only through the sometimes slow coevolution of meaning and understanding that this can take place. What is workable for one therapist, however, may not be workable for another.

Problem versus Problems

When people are struggling with each other, it is not surprising that they will have multiple opinions, resulting in distinct and different descriptions of "the problem." The problem-organizing system view does not imply that there is such a thing as "a" problem, that is, consensus around a definition that reflects an objectified pathology. Problems are linguistic events around which there is often conflicting interpretation. Neither does it imply that the therapist and the client work toward a consensus-problem definition in therapy. There can be as many problem definitions as there are members of a problem-organizing system.

Problem definitions, like the membership of a system, are fluid. Thus, diagnosis is not achieving mutual agreement as to what the problem is. Rather, diagnosis is that early part of the therapeutic contact where the members (communicating network) of the problem system are identified and a dialogue is begun around their multiple views as to the nature of the "problem," their descriptions, and the meanings that it has for them. This can be done in many formats, and it often does not require that all members of the problem system be in the consultation room at the same time. In many instances, such as with agency representatives, therapeutic conversation takes place outside of the therapist's office. These decisions are based on the need to maintain the therapeutic conversation in the interest of coevolving new meaning. They are determined session to session and include both the therapist's and the client's views as to who needs to be in conversation with whom and when. These clinical decisions are not based on predetermined theories concerning the relevant social structure necessary to understand and treat "pathology," nor are they based on hypotheses predetermined to be more useful narratives for the solution of the client's problems.

In this view, the traditional diagnostic processes and categories are of little use because a problem is no more than what the people involved in the communicative-action system are calling a problem. A problem does not exist in any commonalty or category. That is, initially, our clients determine their problem, not the therapist. Thus, the burden of diagnosis is switched from the therapist to the client. In other words, the first step toward a collaborative problem definition is making room for and grasping the client's view. Pre-assigned labels that we often use to understand our work get in the way of collaborative problem defining, and they often describe and create problems that we cannot work with (for example, schizophrenia, juvenile delinquency, denial). It is never helpful to create, or freeze in apodictic certainty, a problem definition that defies new meaning or conversational change. The resulting linguistic immobility becomes only a monologue. In monological conversation, that is, when an idea or aggregate of ideas dominates, new co-created understanding, new shared narrative, and mutual change become increasingly impossible.

It is easy to slide into certainties, into monologues that omit certain views or that hold views that risk linguistic immobility—whether the views are ours, our clients', or our colleagues'. For instance, in our experience, teams established to maintain openness in therapy can by their descriptions turn therapy into a closed process. Teams that aim for consensus often risk minimizing options for both themselves and their clients, and risk operating on the assumption that the team has the more correct diagnosis or hypothesis. Counter to this development, Andersen (1) describes what he and his colleagues call the "Reflecting Team." This is a process whereby team members observing from behind a one-way mirror will then fully share their thoughts with the family and therapist as a way of opening conversation and the development of new meaning. As the Reflecting Team operates, the focus is more on the history and development of ideas than it is on diagnostic formulations or hypotheses. During the interview, the team behind the mirror change places with the family and therapist. In conversation with each other, the Reflecting Team shares its ideas with the family and therapist. The family and therapist then have a conversation about the team's conversation. This may take place several times during the course of a session. The Reflecting Teams and their clients develop ideas and new meanings with each other. In doing this, they are in the domain of conversation, actively collaborating with each other and participating in the development of new descriptions, understandings, and narratives. Such an open, dialogical team easily avoids the "diagnostic" struggles, competitions, and power maneuvers described by Hoffman (36). It also enhances the opportunity for problem defining, and thus therapy, to become a shifting, revising, and collaborative process.

SUMMARY

Some 35 to 40 years ago, there was an optimism regarding family therapy that seems somewhat exaggerated today. The prevailing view of the early pioneers was that family therapy was the paradigmatic shift that would yield complete answers

to the mental health problems faced by clinicians. The prevailing view was that family therapy theory was developing so rapidly that it was only a matter of time before hard work and systematic investigation would generate an integrated body of science and clinical application that could resolve all major issues in the field of psychotherapy. Today, family therapists and theorists are more cautious about what will be accomplished within the next thirty years (48, 50, 65). While the optimism has not entirely vanished, the mood is more somber, and there is considerable talk of the need for integration and even some skeptical counterclaims about whether family therapy really works.

It is our view that family therapy, based on a social theory rooted in Parsonian sociology, has major theoretical and practical limitations. Parsonian sociology is a theoretical model committed to an objective view of the human sciences that distinguishes between the observer and the observed. It is a model that defines social organization on the basis of social role and social structure, and that defines problems (pathology) as a defect in structure. We find it useful to abandon this model of social science and to focus more on the world of meaning and hermeneutics. This model shifts the world of therapy from the world of pathological social structure to the world of meaning. Meaning and understanding are developed by individuals in conversation with each other in their common attempts to understand other persons and things, others' words and actions. Meaning and understanding are thus inter-subjective. This proposed model is a shift from the science of social structure to the science of semiotics. It is a shift to the world of conversation and dialogue.

It would be an obvious exaggeration and mistake to assume that the entire realm of human growth and behavior, the science of psychology, can be assumed under the rubric of conversation and dialogue. Nevertheless, psychotherapeutic activity, the "talking cure," requires dialogue and takes place in conversation. Such a process must be based on mutual understanding, respect, a willingness to listen and to hear, and an openness that is highlighted by seeking the "rightness" of what is said rather than the pathology. This is the essence of therapeutic conversation. It is a point of view that rests squarely on the proposition that the quintessence of what we are, and what we will be, is dialogical. The expertise of the therapist is rooted in, and defined by, the capacity to risk participation in dialogue and conversation, and to risk changing. The therapist's competence is in providing an atmosphere wherein all have the opportunity for dialogical exchange. In doing this, clients demonstrate their own unique expertise regarding their lives, their problems, and their social realities.

In taking this new direction, it seems useful to distinguish our clinical work and the systems we work with on the basis of linguistic and communicative markers. Humans are understood as meaning-generating systems, as a flowing network of interacting ideas and correlated actions. Thus, the social unit we work with in therapy becomes constituted by those who are "in language" about what for them is a problem. Such systems are characterized by communicative action rather than by arbitrary and predetermined concepts of social structure. We call these *problem-organizing, problem-dis-solving* systems.

The process of therapy, within this view, then becomes the creation of a context or space for dialogical communication. In such a communicative space, the membership of a problem-organizing, problem-dissolving system is engaged in the process of developing new meanings and understandings—exploring the unsaid. Therapy, in this view, becomes little more than the opportunity to explore new conversation, new language, and new realities that are compatible with our human tendencies to attribute meaning to our experience with each other. The systems we work with can be conceptualized as existing in language and, therefore, the problems people have can be thought to exist in language. The goal of therapy is to participate in the process of developing a conversational exchange in which problems dis-solve and, therefore, problem-organizing systems dissolve.

Our journey in our search to understand and work with human systems and the problems they present in more effective ways has led us to these ideas. They are evolving ideas that, at this point in time, seem plausible to us. However, we believe that over time and through conversation these ideas will also change. Our original optimism regarding the future of family therapy has shifted to a more cautious view because the accumulation of integrated knowledge within the science of therapy has proved to be more difficult than was originally anticipated.

At the end, we are reminded that we can think of no theory of psychotherapy that has ever been abandoned because of clear observational data and evidence.

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