AESTHETICS AND PRAGMATICS OF FAMILY THERAPY REVISITED

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After reacting specifically to Simon's (1992) proposal for the integration of first- and second-order therapies, I note how he, as well as Anderson and Goolishian (1988, 1990), focus primarily on deliberate, intentional ways to promote a respectful stance in therapy. Although a consideration of which intentional stances and strategies will promote the most helpful conversations in therapy is important, an even more critical question concerns the possible limitations of intentional efforts and the relation of conscious mind to other natural orders of mind in the living world. I suggest that deliberate efforts on the part of therapists toward any intended therapeutic outcomes must be complemented by instinctive and intuitive ways of participating with clients.

In his article, "Having a Second-Order Mind While Doing First-Order Therapy," George Simon (1992) joins a growing number of authors who are concerned that therapists may be inadvertently imposing their own values, ideologies, and agendas on clients under the guise of objectivity. Like others in the second-order dialogue, Simon advocates a nonimposing, nonobjectifying, nonpathologizing process that promotes respect for the views of clients. In my comments on Simon's paper, I will begin by summarizing and reacting to Simon's proposal. Then I will discuss an important way in which Simon's proposal seems very much like the proposal of Anderson and Goolishian, from whom he has differentiated himself. Finally, I will suggest how the proposals of Simon and Anderson and Goolishian can be integrated with those offered by others in the second-order dialogue.

Although the ideals of noncontrolling, nonobjectifying, and nonpathologizing are generally shared by second-order thinkers, individuals have diverged in their ideas about how these ideals can best be promoted. Some have argued that the application of normative theories of health to the therapy setting cannot be done without pathologizing, objectifying, and imposing upon clients (Hoffman, 1985; Anderson & Goolishian, 1988, 1990). Others have argued that normative thinking, assessment, and intervention may be done without imposing, objectifying, and pathologizing (Atkinson & Heath, 1990a, 1990b; Golann, 1988; Keeney, 1982, 1983; Keeney & Sprenkle, 1982). These latter individuals maintain that therapists cannot avoid normative thinking and instrumentalism at some level. For this group, the issue is how therapists communicate their normative values and influence clients, not whether they do. Simon joins the latter group, proposing ways that therapists can use normative theories and attempt to influence clients while refraining from imposing, objectifying, and pathologizing at the same time. Simon's angle of argument is unique, drawing on theories of language which previously have been used to support the opposite assumption, that is, that normative

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thinking, objectifying, and pathologizing necessarily go hand in hand. Herein lies Simon's main contribution.

Simon maintains that certain prevailing sociocultural norms exist in language and that those norms cannot be changed at the whim of participants in specific conversations. These prevailing sociocultural norms must be accommodated to before they can be departed from. Simon assumes that problems arise due to an inadequacy of fit with these norms. Thus, the job of the therapist is deliberately to facilitate a more adequate fit between prevailing sociocultural norms and the structure of client systems. According to Simon, this job can be accomplished by therapists without assuming that these prevailing sociocultural norms have ontological status outside language and that there is an inherent ethical correctness about them. He maintains that therapists can respectfully intervene by being careful not to imply that deviation from these norms is pathological. Simon further maintains that therapists can intervene without being controlling by orienting clients generally in the direction of change while allowing them to work out the specific solutions themselves.

I think there is merit in Simon's contention that there are certain linguistic conventions and constraints that limit the feasible realities that humans can create. I also like his notion that normative preferences can be held without implying that they are "right" in any ontological or ethical sense. Length constraints undoubtedly hindered Simon from articulating in detail all of the ways in which he endeavors to promote a respectful, nonimposing stance in therapy. Therefore, I do not intend my reactions to be criticisms of his work, only reactions to what he was able to say in a very limited space and context. I offer them in an effort to clarify his position. They are as follows: In his descriptions of therapy, I wanted to see Simon more explicitly own:

1. His assumptions that problems arise from inadequate accommodation to prevailing sociocultural norms and that health is promoted by more adequate accommodation.
2. His assumptions regarding exactly what the prevailing sociocultural norms are.
3. His assessments regarding the adequacy of fit between what he has determined to be the structure of client systems and what he has determined to be prevailing sociocultural normative structures.

The extent to which Simon explicitly communicates to clients the position that each of these areas involves assumptions and subjective judgments on his part rather than objective facts is not clear.

Simon's paper has stimulated me to attempt to clarify more specifically what I believe is required of constructivist or social constructionist therapists who intend to be straightforward in sharing their ideas and suggestions with clients. The following are some of the principles which presently guide my practice.

1. Therapists should be careful to present their views as their opinions, not objective facts, and avoid words like "obviously" or "clearly."
2. Therapists should make sure that clients know that their views do not necessarily represent the consensus of other therapists in the profession.
3. Therapists should invite each client to evaluate the therapists' ideas based on how sensible they are to the client, not based on how authoritative or confident therapists seem to be.
4. Therapists should explicitly invite clients to disagree and to take an active role in creating ideas that make the most sense to them.

Some of the above could be accomplished before beginning therapy through an "informed consent" statement. I sometimes begin therapy with a narrative such as:

Before we begin our sessions together, I want to be clear about how I view the counseling process. First, in the field of psychotherapy, I don't think we ever talk about
facts, we talk about opinions. I think it's likely that if you went to five different therapists this week with the same problem, you might very well get five different ideas about why the problem exists or what can be done about it. If a therapist tells you, "It's obvious that this is the problem . . . ," I believe that you should be skeptical. You should also know that there are therapists who disagree with me about this and who really do believe that their judgments are objective. I'm just telling you that I don't believe that their ideas or mine are objective.

This doesn't mean that I don't think that the ideas of therapists are valuable. Any one of these five therapists might be very helpful to you, but they may each proceed under different assumptions. I have accumulated a certain amount of experience in this profession, I've read widely, and I've developed a certain group of assumptions and opinions about how to make sense of problems and what to do about them. I'll tell you honestly what I'm thinking as we go along. Sometimes I get pretty enthusiastic about my ideas, and you'll probably sense this. I suggest that you always try to keep in mind that no matter how animated I get, these are just my ideas, not facts, and I'd like you to judge them on their own merits. Please feel free to disagree with me and tell me what you think. The most useful ideas in this process may occur to you, not me.

I think that statements like this one, if maintained throughout the course of therapy, go a long way toward creating a nonobjectifying, nonimposing therapeutic context. Nonpathologizing seems to have more to do with the nature of the specific normative explanations the therapist may offer. Some general normative explanations about health imply pathology (e.g., DSM IIIR diagnoses) and some don't (e.g., the MRI assumption that a healthier situation might emerge if people changed their attempted solutions). Therapists are free to choose explanations that are nonpathological.

ELEVATION OF DELIBERATE THOUGHT AND ACTION

Although Simon carefully differentiates himself from Anderson and Goolishian (1988, 1990), he also shares an important assumption with them that differentiates him (and them) from others in the second-order dialogue. Simon and Anderson/Goolishian apparently share the assumption that a noncontrolling, nonpathologizing, and nonobjectifying therapeutic process can be achieved through deliberate and conscious attempts to be noncontrolling, nonpathologizing, nonobjectifying, curious, respectful, and so on. In other words, one can be successfully noncontrolling through consciously trying not to be controlling. Simon and Anderson/Goolishian engage in very different kinds of deliberate activity intended to promote noncontrol, but their common assumption is that it is possible to control one's controlling deliberately.

I endorse the idea of trying to be less controlling, pathologizing, and objectifying, and I think therapists should do all that can be deliberately done toward this end. I am pleased with the surge of articles that have appeared in the last decade (of which Simon's is only the most recent) that have proposed ways in which therapists can consciously pursue a respectful stance in therapy. However, following Bateson (1972, 1979, 1991, Bateson & Bateson, 1987) and Keeney (1982, 1983; Keeney & Sprenkle, 1982), I have also argued that conscious, deliberate efforts will likely not be sufficient to ensure a respectful, collaborative process (Atkinson & Heath, 1990a, 1990b). Bateson (1972, 1979, 1991, Bateson & Bateson, 1987), one of the first "second-order" thinkers to influence our field, argued that the conscious mind is limited in its ability to perceive pattern and that unless conscious mind is adequately coupled with higher orders of mind, it will lead to fragmentation and dysynchronization of ecologies. Bateson wrote that conscious mind must be recursively connected with other orders of mind that operate at a more basic or instinctual level. Influenced by Freud's notion of the id, Western culture has developed a deep suspicion of mental processes that regulate at an instinctive level, and a decided preference for conscious, deliberate control. Instinct is thought of as something appetitive and selfish that must be controlled through conscious mind.
NATURAL ORDERS OF MIND

Freud's influence is not universal, however. For centuries, philosophers, scholars, theologians, and more recently natural scientists have argued that there are natural orders of mind in the living world that promote harmony and balance. These orders of mind apparently have little to do with conscious thought (Hayward, 1983). Examples of natural orders of mind are widely available—the organs of the body instinctively know how to regulate changes in breathing, circulation, digestion, and internal temperature without the aid of conscious reasoning; the fingers of the hand work together effortlessly without thinking about it; the plant and animal systems of the earth appear to work together in delicate balance.

It can be argued that there are two kinds of control that occur in the living world. One kind of control is engineered through deliberate, conscious human effort. The other kind of control occurs naturally, instinctively, through orders of mind that are basic to both the human and nonhuman living world alike. Modern society has developed a decided preference for conscious control and largely neglected the more mysterious patterns of control that appear to organize the vast majority of the living world. However, this need not be the case.

Although socialized in a Freudian culture, I have come to believe that human instinct is basically positive and naturally oriented toward promoting ecological harmony and synchrony. Fragmentation arises when conscious purpose (which is only part of what is natural to humans) is elevated above that which is instinctive. I have come to suspect that when conscious, deliberate action is conceived and implemented in contexts that do not equally facilitate instinctive, intuitive processes, the result is separation and fragmentation, even if conscious intentions are to promote harmony and cooperation.

SECOND-ORDER THERAPY

I believe that the deliberate pursuit of a nonimposing stance in therapy must be accompanied by a more fundamental human process that has more to do with a willingness to go on instinct, learn by mistakes and experience, and permit the expression of natural, honest reactions that aren't first calibrated through the strategic properties of conscious mind.

I like very much Anderson and Goolishian's (1988, 1990) idea of therapy as nonhierarchical conversation, but I believe that the conversation must be a dialogue of whole persons, not just a meeting of the minds. My concern is that, in an effort to be noncontrolling, therapists themselves may become too self-consciously controlled. Such therapists may be deliberately respectful but fail to connect personally with their clients. Therapists must be willing to participate in conversations as full persons, not just as conscious commentators on experience. Therapists must act on the basis of instinct and intuition, sharing their honest, initial reactions and feelings with clients as well as their more carefully deliberated thoughts and actions.

The hallmark of first-order therapy is deliberate, conscious intention. For second-order therapy to occur, as I see it, therapists must not only make deliberate efforts to be nonpathologizing, noncontrolling, and nonobjectifying, but they must also recognize that conscious intention alone cannot succeed. Rather, deliberate thought and action must be integrated with the instinctive thought, feeling, action, and expression in therapy. Of course, elevating instinctive process above conscious, purposeful process would likewise be problematic. It is the recursive connection between the deliberate and the instinctive that enables the emergence of aesthetic pattern, harmony, and synchrony.
These points have been made previously by Keeney (1982, 1983) and Keeney and Sprenkle (1982). In fact, Keeney and Sprenkle's (1982) paper on the place for pragmatics within an aesthetically based family therapy sparked vigorous debate in the mid 1980s. However, these issues have disappeared in much of the recent second-order dialogue.

In his paper, Simon (1992) has provided us with some ideas about deliberate actions therapists can take to pursue a respectful stance in therapy. His suggestions are significantly different from those of Anderson and Goolishian (1988, 1990), but I believe that both his and theirs have a valuable place in a second-order family therapy. However, I propose that their suggestions for consciously and deliberately assuming a respectful, noncontrolling stance must be complemented by an equal valuing of less deliberate processes in therapy if patterns of natural healing and synchronization are to emerge.

One final word of qualification for clarity's sake. I do not think that there is anything necessary or obvious about the distinctions I have proposed in this paper. Nor do I assume that they will make as much sense to others as they do to me. I present them in an effort to direct conversation toward what I believe to be perhaps the most fundamental issue facing human kind.

In addressing the problems of this century, modern society has limited itself largely to what can be done with deliberate thought and action. Although the question of which intentional stances and strategies will promote health will continue to be important in the future, an even more critical question concerns the limitations of what can be accomplished through intentional efforts and the relation of conscious mind to other natural orders of mind in the living world.

REFERENCES