

# Persons and Hypotheses: The Use of the Therapist in the Hypothesising Process

Paolo Bertrando and Dario Toffanetti

Although hypothesising has been strongly criticised by postmodern and narrative theorists, it plays a major role in any therapy. This article aims to investigate the hypothesising process, first revisiting the concept of hypothesis in semiotics and Schön's theory of the professions, then examining some features of hypothesising within systemic therapy. The article takes into account the relationship between hypotheses and therapists' basic theories, to arrive, finally, at an examination of the role of the person (both therapist and client) in shaping hypotheses within the therapeutic interaction.

Hypothesising should be considered part of the acting and thinking (explicit or implicit) of all therapists, independent of their theoretical orientation. According to Lester Luborsky (1984), for example, the interpretative process in psychoanalytic therapy, focusing initially on the symptom, progressively defines a 'core conflictual relational theme', on which the therapist works together with the client. This is essentially a process of hypothesising.

Within the family therapy field, the most important version of the idea of the hypothesis was enunciated in 1980 by the original Milan team (Selvini Palazzoli, Boscolo, Cecchin & Prata, 1980). Their paper established three principles for systemic work: hypothesising, circularity and neutrality, which drew the Milan school away from the MRI systemic-strategic model (Watzlawick, Jackson & Beavin, 1967) and brought Bateson's ideas back into focus (Bateson, 1972). Of the three principles, hypothesising is the closest to the Batesonian idea of 'mind' (Bateson, 1979): in therapy, connections are created by constructing temporary hypotheses about the patterns of relationships between clients; different interpretative possibilities engender ideas that can be shared with the clients. In the team's words:

The hypothesis, as such, is neither true nor false, but rather, more or less useful ... For exactly this function of categorizing information and experience, the hypothesis occupies a central position among the means with which we discipline our investigative work ... The functional value of the hypothesis in the family interview is substantially that of guaranteeing the activity of the therapist, which consists in the tracking of relational patterns ...

The hypothesis of the therapist, however, introduces the powerful input of the unexpected and the improbable ... and for this reason acts to avoid derailment and disorder (Selvini Palazzoli et al., 1980: 4).

Milan hypotheses were born out of teamwork. In *Milan Systemic Family Therapy*, Boscolo, Cecchin, Hoffman & Penn present a complete original Milan Team session, including the team discussion. One of the characteristics peculiar to the session is that '... the discussion which accompanies the case goes back frequently to the aim of the structure of the team, as well as to its function and limitations' (Boscolo et al., 1987: 38). Mirroring the feelings of the family, the team reflects on its rules and the process that brings it to a certain view of the facts. The hypotheses undergo changes and transformations in the course of the team discussion. The process depends on the development of different ideas, which appear to be variations on the central theme. In Luigi Boscolo's words: 'When the general hypothesis is accepted by all members of the group, you may go on refining it until it gathers some sense' (ibid.: 88). The structural analogy to Luborsky's idea of the interpretative process in psychoanalytic therapy is surprising, although the rationale and the content are different.

Today, many conversational and narrative therapists regard hypothesising as oppressive and recommend the therapist eschew it in order to avoid forcing the clients' vision into the therapist's categories (Anderson & Goolishian, 1992; Andersen, 1991). We might ask ourselves, though, whether therapists who maintain that they form no hypotheses really do so. In our opinion, not even the most respectful and 'not-knowing' conversational therapist can work without hypothesising at all.



**Paolo Bertrando** is a Psychiatrist and Psychotherapist, Director, Episteme Centre, Turin, Italy. Address for correspondence: Piazza S. Agostino, 24, 20123 Milan, Italy. Ph. 0039 024819054; email: gilbert@fastwebnet.it

**Dario Toffanetti** is a Clinical Psychologist, The Milan Centre for Family Therapy, Milan, Italy.

However, the question of *how* an hypothesis is formulated remains open. What resources does the therapist call upon when formulating it? When the therapist decides on one hypothesis rather than another, which criteria does s/he use to make the choice? We believe that the generation of therapeutic hypotheses is inextricably linked both to the self of the therapist and to her position within the therapeutic context. To understand the hypothesising process fully, we should take into account the complex relationship that is established between therapist(s) and client(s), with all its personal and professional determinants. The therapist's theory, in this view, is but one of the factors. We could say: 'It is impossible to formulate a (significant) therapeutic hypothesis, without including the therapist in it'.

In this article we will seek to understand the formal character of hypotheses, look at what is unique to systemic ones, and discuss the relationship between hypotheses, theories and therapists as persons.

### An Example: The Compromised Betrothed<sup>1</sup>

Renzo and Lucia are a 34-year-old couple. Professional people, they have lived together for eight years and have two children, aged seven and three. They are content with their respective careers, and speak of a pleasant harmony of interests, as well as a moderately good sexual relationship. The problem they bring to therapy consists of quarrels that may be bitter, at times even violent, subject to sudden escalation, which neither of them is able to control. These seem to occur in spite of themselves. The quarrels have always been there, they say, but they have become more and more serious and, since the birth of the second child, they have become weekly occurrences. Generally Renzo attacks, as he himself admits, but the only substantial criticism he makes of Lucia is that she is too dependent on her mother, who rings Lucia every day. 'It's true', Lucia admits, 'My mother is, and always will be, a constant point of reference: if I need some advice, I consult her, and I trust what she tells me.' Lucia does not herself see the relationship as excessively close. She sees it mainly as a problem of Renzo's making.

The therapist looks closely into the details of the current couple relationship, feeling a growing perplexity about those quarrels that seem to have no cause, almost as if they concern someone else. He<sup>2</sup> decides to explore their family background, and discovers that Lucia's parents realised early on they were not right for each other. ('Probably they already knew it at the time of my birth', Lucia says) but decided, 'for their children's sake', to go on living under the same roof, though separated, and in this way they spent over thirty years. The children soon perceived how things were, in their early teens in fact, but without (according to Lucia) feeling particularly perturbed. The parents stuck to that arrangement until exactly two years before, when they initiated a legal separation. ('But actually, they are not really separated. It's as if nothing has changed', Renzo points out.)

Renzo, on the other hand, comes from a less affluent family that he perceives as relatively cold, but tightly knit and, according to Lucia, fairly reserved. When he met Lucia, he had been married for one year, but chose to put an end to his marriage at once. His decision did not meet with his parents' whole-hearted approval. Despite this, he decided to leave his marital home immediately and move in with Lucia, in her parent's house.

At this point, the therapist begins to have a few ideas of his own. From all that has been said, it is obvious that the tie between Lucia and her mother is strong and deep. He then inquires about the relationship between Renzo and Lucia's father. The reply is: 'When I moved in, I noticed that that man, who to me seemed both pleasant and very cultured, was treated shabbily, pushed aside, yet he was so kind and agreeable that he didn't even mind. It made me rather cross.'

Through a series of further questions, the therapist refines his hypothesis. Originally, he was struck by the fact that Renzo and Lucia experienced their fights as if somehow they were not the protagonists of their own quarrels. Later, having realised that one of the families of origin, Lucia's family, has been involved in the quarrels, he directs his inquiry there. Listening to the conversation, he notices the difference between Renzo's ideas and feelings and the arrangements adopted for the sake of peace in Lucia's family of origin. This leads him to hypothesise that the quarrels might depend, at least in part, on an identification of the two partners with another married couple, in this case Lucia's parents. Renzo, with his sensitivity to order and justice, feels bound to right the wrongs done to the other man, whom he respects. Lucia, out of loyalty to her mother and the choices made by her family, to which she feels obligated, experiences in turn the need to defend her mother from those attacks that she finds gratuitous and unmotivated.

The couple's answer when this hypothesis is put to them is essentially positive and the therapy continues along other lines.

We could ask ourselves: how did the hypothesis take shape? This question suggests another: how is an hypothesis structured? The field of semiotics provides a first answer. Charles Sanders Peirce (1931: 58) offers a pragmatic definition of the structuring of hypotheses in formal logic: everyone confronted by the unknown creates an 'hypothesis' in order to give the new experience some sort of sense. The wisdom people acquire through the passage of time helps to refine their learning from subsequent experiences.

Peirce attributes the greatest importance to inference as a logical tool: thought in its wholeness is an inferential process. According to Peirce, '... hypothesis is simply an induction which concerns qualities, rather than things' (ibid.: 37). In the theory of knowledge, an hypothesis is an approximation, for it is not given to us to be acquainted with the infinity of the possible natures of things. Seen from this perspective, an hypothesis is a bridge between the indeterminacy of impressions and mediated pieces of cognition. A stream of inferences is our only possible way to knowledge.

If we apply these concepts to the work of the therapist in the vignette above, we discover that here, too, the process of approximation has created analogies between different situations. The process appears to us to follow this sequence:

1. First of all the therapist draws a provisional map of the problem, analysing the relationship between the couple, and realising that the quarrels seem to occur 'in spite of them'. Therefore he looks for a context that might be the source of the conflict. (*In which context does the conflict exist?*)
2. He tentatively matches the map to the context of the families of origin. (*Could the conflict be found in the families of origin?*)
3. Concentrating on Lucia, the therapist creates a pattern which connects her family of origin with her present family. (*What is Lucia's position in relation to her family of origin?*)
4. Subsequently the therapist creates a pattern which connects Lucia's family of origin with Renzo. (*What is Renzo's role in relation to Lucia's family of origin?*)
5. The two patterns are related through the idea that the roles within the couple framework are isomorphic with the relationship between Lucia's parents. (*Do Renzo and Lucia play roles that are borrowed from Lucia's family of origin?*)
6. The hypothesis is then checked against other sources of information. (*Does any of this make sense to either Renzo or Lucia?*)
7. Lastly, the therapist assesses the congruence of the feelings expressed by the couple after they have heard the hypothesis.

This analysis shows how the construction of an hypothesis has to do with the layering of 'provisional ideas' which define a new connection between the clients' behaviour and emotions. Having decided upon an opening, the therapist begins, together with the clients, to look for both new data and new links that might lend meaning to what would otherwise seem strange and inappropriate. Progressively, the therapist asks himself and his clients questions that connect people who are significant in their world, until a coherent pattern emerges. At the same time, this is but one of the many possible patterns whose validity is underwritten 'with four hands' by both clients and therapist (Boscolo & Bertrando, 1996). The therapist in this vignette draws on his personal repertoire of hypotheses. But where does this repertoire come from?

### The Hypothesising Process

From an epigenetic perspective, therapists' knowledge (of themselves, of others, of both theories and methods) settles progressively into layers, leading to a constant re-integration of the situations and contexts in which they find themselves: hypothesising is part of the development of

knowledge out of experience. Peirce's abstract theories are consistent with those advanced by Donald Schön (1983).

According to Schön, when professionals (therapists included) find themselves confronted by a new situation, they set in motion procedures that will enable them to connect the data at their disposal with their ideas about how problems arise. This is their way of addressing a complex series of variables, with the hypothesis as sole instrument, guided by the situation's 'back-talk', i.e. the way in which the situation responds to the practitioner's actions (Schön, 1983: 164). In Schön's words, a professional does not look for general laws, but for solutions in specific cases; therefore an hypothesis needs to be adopted provisionally (and not 'disconfirmed' in the Popperian sense), i.e. it should lead to some significant change in the particular situation being tackled by the professional.

The inquirer must (...) be willing to enter into new confusions and uncertainties. Hence, he must adopt a kind of double vision. He must act in accordance with the view he has adopted, but he must recognise that he can always break it open later, indeed, *must* break it open later in order to make new sense of his transaction with the situation (Schön, 1983: 163–164).

Therapists may be considered professionals who are able to resolve the kinds of situations which require a reorganisation of the field of inquiry every time. Such a reorganisation is highly related to the therapists' subjectivity. Among the elements that contribute to it, we may list the goals that therapists define (the patients' well-being, the disappearance of a symptom, the modification of a relational pattern or of the patients' personalities); the therapists' expectations about their work (how they evaluate and monitor the outcome); their clinical theories (including hypotheses about the origin of pathology); and their techniques.

In interaction with clients, theories function as useful points of reference, but do not 'dictate' directly the therapists' moves in their dialogue with the situation. In the course of their experience, therapists build up a repertoire of 'examples, images, explanations and actions' (Schön, 1983: 138). Within this repertoire, they are able to select other situations which have similarity to the one they are approaching. Once they have 'composed' a theme, therapists can ring changes on it.

Therapists produce what Schön calls 'generative metaphors', non-logical images, in which the likeness between a new situation and one that has already been experienced is *metaphorical*. It is possible for therapists to explicate a metaphor to themselves as well as to clients, just as it is possible for this not to happen and for therapists to operate without translating the metaphor into a proper hypothesis.

Much as they might attempt to influence the therapeutic situation (as opposed to the clients' lives), therapists do not build self-fulfilling prophecies. Rather, they remain open to the possibility that events will not comply with their hypotheses.<sup>3</sup> At the same time, unlike scientific researchers,

they are not detached from their hypotheses, do not consider the clinical situation a neutral object to be studied:

The relationship between this inquirer and this situation is transactional. He moulds the situation while conversing with it, so that his models and evaluations are in turn moulded by the situation. The phenomena he attempts to understand are partly created by him; he stays in the situation which he attempts to penetrate (Schön, 1983: 150–151).

The process of hypothesising is thus deeply shaped both by the therapists' premises and by the contingencies, which are related recursively and are occasioned by the clients' specific situations.

Here hermeneutics may provide a central point of reference: hermeneutics is pervaded by the awareness that every meaning is an interpretation and that 'truth' is meaning shared between parties, not something that is 'given' in an absolute sense. Gadamer (1960: 272) defines the convergence of meanings produced by story-teller and interpreter as 'a fusion of horizons' (Gadamer, 1960: 272). For Heidegger, understanding is circular, since the local conversation is modified by its global context, which in turn is modified by local conversation and so on. Heidegger (1927) calls this hypothesising the 'Hermeneutic Circle'. In systemic therapy, hypothesising assumes a similar meaning — it is a transitory and renewable aspect of the reading of events.

### The Role of Hypotheses

In a therapeutic situation, two individuals<sup>4</sup>, both endowed with their own store of knowledge as well as their own typical manner of hypothesising, meet and seek to invest with meaning the story told by one of them. This story is usually replete with apparent certainties: the hypotheses on which the current, reified notions are based have receded into the past, the resulting meanings are crystallised and time stands still (Boscolo & Bertrando, 1993).

While the client narrates his/her story, the therapist has a basic assumption: she knows that she will attempt to modify the meaning of the story, for a story always has more than one meaning. In order to achieve this aim, she will select some facts (but not others) and will look for a connection between them. Then she will build some hypotheses on some of the connections (but not others), starting to delineate a theme, a pre-hypothesis. She will labour for some considerable time in a dimension devoid of certainties.

But is it really true that she has no certainties? Her selection of facts and connections will in fact have gone through her personal filter, sifted from the whole body of her experience, training, and emotional awareness. In a word, she will use a repertoire of hypotheses based on her own premises. Freud's repertoire was based on the idea of sexual drives, Adler's hypotheses started from the perception of people's power relationships, Nagy inquired into the ideas of ethics and loyalty, Whitaker foregrounded chaos and indeterminacy, and Paul, mourning. Each of these master therapists focused on one of his *a priori* preoccupations, from

which he derived points of reference structured by his previous knowledge and experience: all this is highly congruent with Peirce's view on the stratification of knowledge.

Turning back to our typical therapy, the therapist will be led to formulate hypotheses which resonate with her basic premises, and with these hypotheses she will select and reinterpret particular themes from the client's story. One might say that it is not only the client who believes she is describing a unique, unrepeatable human situation: the therapist, too, is doing so. Therapists, however, tend to be more predictable than their clients, for they always have a definite theory they refer to, whilst their clients do not, or at least not always.

So far, we have dealt with features common to therapeutic hypotheses of any kind. But what are the special features of systemic hypotheses? Is hypothesising just another name we give to existing concepts, such as psychoanalytic 'interpretation'? In fact, we believe it is possible to draw a distinction between the two. First of all, psychoanalytic interpretation is more directly linked to a normative theory of the human person: all analytic interpretations assume that the unconscious needs to be made conscious (Laplanche & Pontalis, 1967). Furthermore, different analytic schools put emphasis on different content: Freudian interpretations refer to an internalised past, Kleinian interpretations to a timeless unconscious, and so on. In systemic hypothesising, the approach is less normative: the hypothesis *may* refer to the past, or to the present, and could even refer to an imagined future (see Boscolo & Bertrando, 1993). We could say that analytic interpretation is one special case of the general hypothesising process, and systemic hypothesis is another.

Furthermore, while analytic interpretation is focused on the two-person therapeutic relationship, a systemic hypothesis — even in an individual setting — takes into account a wider range of information drawn from the clients' lives. In a systemic hypothesis, the relationships of the clients to their significant environment are always central. Systemic therapists always search for the context that produces problems or symptoms. The relationship of single clients to themselves (or their unconscious, or their internalised objects) may be considered, but this is by no means mandatory (see Bertrando, 2002).

Like any hypothesis, a systemic hypothesis also has an emotional fit with the presenting system. Therapists single out certain emotionally fundamental aspects of the situation and return them, modified, to their clients. This means that the hypothesis is not simply a cognitively coherent reorganisation of data, rather, it should be also congruent with the emotions inherent in the family's interaction. The test of the hypothesis lies in the emotion. This process works on the fundamental assumption that therapists can recognise within themselves the same emotions as their clients are feeling and couch them in 'unusual' words (Andersen, 1991), i.e. in a way that is acceptable and not alienating for the clients. Unlike the analysis of countertransference in which the *therapist's* emotion is the criterion for truth in the therapeutic

relationship (Searles, 1979), systemic praxis asserts, first, that therapist's and clients' emotions do not simply 'correspond' in a mechanical manner, and second, that therapists' emotion and the construct on which it is based must be verified by means of an hypothesis.

In their hypothesising, systemic therapists often tend to construe situations as individual and unique. This is perhaps one of the most significant elements of the systemic approach, epitomised in the notion of 'curiosity' (Cecchin, 1987). Such a premise leads systemic therapists to act each time as if every situation were new, enabling them to formulate hypotheses that might well have nothing to do with those formulated in the preceding session. Equally, they know that systemic praxis tends to focus attention more on the relationships between facts and theories than on facts or theories in themselves.

What, then, is the relationship between theory and hypothesis? To a certain extent, the theory dictates the hypothesis. However, a theoretical model does no more than suggest possible lines of enquiry within the field of the therapists' experience, their style, and the events of the therapy — it is a process that is both personal and context-specific. To form hypotheses is undoubtedly an important part of the therapeutic process, yet it isn't the whole of therapy. Our proposal gives priority to a series of non-specific therapeutic factors (Hubble et al., 1999), out of which will gradually grow a way of hypothesising which is extremely structured, yet which cannot be replicated via a manual. There have often been clashes between the idea of technique as central, with little or no consideration for the therapist's person (strategic therapy), and the idea that what matters is the therapist's participation as a person in what is essentially a dialogue (narrative and conversational therapies).

In our opinion, some therapeutic factors are fundamental, whatever the therapist's theoretical position may be. Possibly the main one is the necessity for a therapeutic alliance. Within this, the 'principle of trust', as Umberto Eco defines it, may be established between client and therapist:

We think that the principle of Truth may obtain in the real world, whilst in the narrative worlds the principle of Trust must count. Yet even in the real world the principle of Trust is as important as the principle of Truth (Eco, 1994: 109).

In the therapeutic context, hypotheses become true both for therapists and clients, given that a relationship of trust exists and shapes the possible interpretations of the clients' contribution. In this sense we may say that the efficacy of hypotheses is dependent upon the quality of the relationship between client and therapist. In Batesonian terms, the frame for the hypothesising activity is enclosed in a larger frame, which refers to the relationship between the participants. It is within the therapy hour that a sacred time, as Eliade (1949) defines it, comes to exist, i.e. a time that is set apart from everyday existence, therefore able to impart special meaning to the events that occur within it.

## Hypotheses and Therapists

What guides therapists, then, in the conjoint exploration they undertake with their clients? A 'self' in which both theories and experiences take part.

Nowadays, from a postmodern perspective, we tend to consider a theory little more than a good repertoire of metaphors (Pocock, 1995). This may imply a risk of eclecticism: I choose my theory according to the specific problem I am facing. The issue is, however, that it is the theory that determines, in many ways, just what I might consider a problem. The theory comes before the problem. If a therapist maintains that he has no theories up to the time when he begins to solve the problem, we fear that he may have nothing but implicit (unconscious) theories, which produce untold<sup>3</sup> hypotheses.

On the other hand, the more experienced therapists are, the less they follow the theory; they care more about the way situations respond to them (the 'back-talk') than about the theories in their heads. From an epigenetic perspective (Bertrando, 2000), which may help resolve this contradiction, therapists are guided by the sum total of the theories they have learnt and used in their professional practice, as well as by the unique experiences of their own lives. Therapists submit any problem that confronts them to this personal 'compendium' of theories and experiences.

The following example demonstrates 'back-talk' focused on the therapeutic relationship. Lucretia began couple therapy after her husband's decision to separate from her and their sons, aged six and eleven. She convinced her husband to participate in two sessions, but his decision seemed irrevocable and his motivation for treatment non-existent. Lucretia, following the therapist's suggestion, continues with treatment individually. The problem which had triggered the couple's crisis was, according to her husband, Lucretia's tendency to aggression, her harsh communication style, and her inability to express positive feelings towards him. Lucretia accepts the therapist's view of her as 'gutsy', but says that her husband is 'feeble and passive', and that his relational style is deeply disturbing to her.

In the beginning, Lucretia's motivation for individual therapy was openly linked to her hope of getting her husband back, but, as the treatment goes on, she becomes more and more interested in her personal story, and in discovering the meaning she gives to her relationships. During the sessions, the attitude she displays towards the therapist seems ambivalent: sometimes she asks for suggestions about how she should behave with her husband and children; this seems to the therapist childish and passive, and arouses in him a feeling of being a dominating, parental figure. At other times (sometimes in the course of the same session), she seems defiant towards the therapist, telling him how she has been assertive on several occasions in her daily life. This second attitude elicits in the therapist fear and a feeling of needing to protect himself.

The therapist confronts what he deems to be veiled aggression, naming 'rage' as the prevailing affect in the first

few sessions, and connecting Lucretia's attitude towards him with her relationship with her father. As a child, she was faced with her father's verbal and physical violence to both his wife and his daughters. Thus, for Lucretia, her family is polarised between 'totally good' (her mother) and 'totally bad' (her father).

When her attention is drawn to the parallel between her attitude to her father and her attitude to the therapist, Lucretia finds it difficult to accept, but the therapeutic relationship changes to a growing trust in the therapist and an acceptance of her dependence, including the 'feebleness and passivity' she used to scorn in herself and her ex-husband. Furthermore, when Lucretia had to deal with people she perceived as 'passive', she tended to revert to the 'good/bad' split which dominated her relational semantics, and became aggressive. But, in that stance, she had to confront a deep sense of guilt, originating in her personal history. To understand this, the therapist drew on his own family of origin experience: his parents' relationship had been similar to hers. (The therapist took the problem of his own identification with his father to his personal therapy.)

The therapeutic principle informing this intervention is similar to the one described by Stolorow and Atwood (1992). The aim is to assist the client to integrate and tolerate affect within an intersubjective dynamic system such as the therapeutic relationship, which then becomes a primary factor in the client's evolution. The client is not requested to change her premises altogether, but rather to integrate her past relational experiences with the present ones, and, at the same time, to integrate negative experiences or affect with a different awareness: affect is something to talk about, rather than act upon.

In terms of hypothesising, we find here something similar to the 'isomorphism process' described by the original Milan team: in the case we presented first, the therapeutic team discussed the analogies between family dynamics and team dynamics.<sup>6</sup> Here, when working with an individual, the therapist wonders about the emotions his client stirs in him, using the therapeutic relationship as a tool for verifying his hypotheses about the client's relational modes, within a therapeutic system charged with emotions.

The contradiction between the use of theories and the use of the therapist's experience is more apparent than real. Analysing the relational patterns woven by client and therapist (and their associated emotions) is an activity where theory and practice fuse together, involving the therapist in the scrutiny of his own behaviour patterns and emotions. Such an operation is impossible without a definite theoretical framework.

If we turn back to the first of our case examples — which we earlier described as if the hypothesis had been built without specific use of the therapist's self — we can find traces of the latter, nonetheless. In building his hypothesis, the therapist selected those very elements in Renzo and Lucia's story that were related to their families of origin — the gender relationship within the respective families, and the relevance of the two family dynasties. In the

hypothesis, Renzo saw his position vis a vis Lucia as similar to that of Lucia's father vis a vis Lucia's mother; at the same time, he viewed himself as representative of a family less important and powerful than Lucia's. In defending Lucia's father, he was defending himself.

In a further stage, the therapy reached an impasse: the therapist became stuck on the hypothesis (layered onto the original one) that Renzo and Lucia 'are not yet married', and should become 'a real couple' (i.e. detached from their families of origin). Supervision revealed that this very topic had been central in the early stages of the therapist's own marriage, and was closely linked to his family of origin: his father, he sensed, had been accepted in his wife's hospitable, powerful family, but the price was that his father had felt tolerated, like a 'guest'.

Thus, in this case, too, the therapist's self (family history) was essential both in the therapeutic process and in the construction of the hypotheses. The therapist did not deliberately call it to mind, but it became apparent when he tried to understand how he had built the hypotheses, and why he was unable to change them. Being largely unaware of the process, the therapist tended to cling to his first hypotheses, even when the situation demanded a radical change.

Thus, the hypothesis can be seen as coming from the interaction between therapists' personal histories and the clinical situations they have to face. What applies to the therapist (or the team), applies equally to the client (or clients). The latter too, have a story that will lead to a dialogue with the therapists and they too will choose, among the suggested hypotheses, one or more which allow them to find some fit. In this way, the hypothesis examined during therapy does truly emerge from a dialogue.

In the end, probably, all therapists or teams may have to consider an hypothesis that includes the therapeutic relationship, even if this does not occur through the metaphor of the transference (Bertrando, 2002). The emergence of such hypotheses is almost inevitable, if therapists are prepared to grasp them. To neglect them risks reifying hypotheses built 'outside' the actions and narratives of the clients, leading to interventions that miss significant impasses for the client in the here and now of therapy, as Lannamann (1998) has shown.

### Uses of the Hypothesis

We have said how, in our opinion, an hypothesis is formulated. But one problem remains: how open to be about an hypothesis within a therapeutic session? The original Milan group, in the period up to the 1980s, assumed that the therapist's or the team's hypothesis should not necessarily be expressed to the clients. In its place, a reframing, a prescription or a ritual was supplied. In such a procedure, the verbal dimension is deliberately minimised and action is the privileged channel of communication. All this has a great deal to do with the idea of therapy as a time for ritual, but also reflects a directive stance subsequently repudiated by the systemic therapies.

Narrative and conversational therapists (Andersen, 1991; Anderson, 1997; White, 1995) find therapy 'played with the cards face down' unthinkable: the client is always treated as equal both from the ideological point of view and in terms of co-responsibility for the outcome of therapy. It is congruent with this approach to assume that we should not arrive at hypotheses immediately, so as not to be either dominating or manipulative.

In each of the cases we have presented, the therapist informs the clients of the opinion that has been formed about them and of the hypothesis that connects their histories. This idea represents a possible middle ground between the two opposite positions. To keep the hypothesis a 'secret' may mean that the person we are speaking to is patronised; on the other hand, our attempt *not* to have ideas suggests a fear that clients might not tolerate our ideas of them — which is surely patronising too! At this point, the two positions seem far more alike than we had thought at first.

We believe that, if the principle of trust between client and therapist really exists, any suitably selected idea can be suggested to our clients. It will be left to the therapists, however, to choose the right words, the right phrasing, so that they may offer their ideas to their clients in a respectful and positive way (Boscolo, Bertrando, Fiocco, Palvarini & Pereira, 1993). Clients will certainly not be harmed by our words. If anything, they could be hurt by the implicit message that we consider them dangerous, as well as unable to understand themselves. In this way, the interplay of clients' and therapists' hypotheses within the therapeutic dialogue will (hopefully) help generate better ways of approaching life — for both therapist and client.

## Endnotes

1. A play on the title of Alessandro Manzoni's famous Italian novel, *I promessi sposi* [*The Betrothed*].
2. The therapist in the clinical vignettes is always in the male gender, because both vignettes are taken from our own cases.
3. This attitude is analogous to circularity, as defined by the Milan School (see Boscolo et al., 1987).
4. We shall limit ourselves to the typical case of individual therapy, but the process is essentially the same when therapeutic teams and families are concerned.
5. For the concept of the 'untold', see Boscolo and Bertrando (1996).
6. During the team discussion, Mara Selvini Palazzoli said that at the beginning of the session the therapists had talked a great deal, felt intimate and felt also that they must be a good family, thus living an isomorphism with what had been perceived about the family during therapy (see Boscolo et al., 1987: 81). The basic premise is that the occurrences within the family may be analysed by observing the team dynamics (of course, we might ask ourselves whether it is only the family that influences the team, or the other way round as well).

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## ANZJFT Authors Noticed Abroad

Mark Rivett writes an annual review of family therapy journals. Blackwell Publishers have kindly given permission to produce extracts from 'The Family Therapy Journals in 2001: A Thematic Review', by Mark Rivett (*Journal of Family Therapy*, 2002, 24, 4: 423–435). Mark writes: 'The year 2001 saw a substantial expansion in articles that sought to increase family therapists' knowledge of couples therapy' (424). Naturally enough, some of these papers made 'a return to an earlier controversy' (ibid.) about how domestic violence alters the arrangements for couples therapy.

However, Hunter (2001) highlighted the controversies surrounding this issue more fully in a section in *The Australian and New Zealand Journal of Family Therapy* by describing the ethical dilemma family therapists face in dealing with domestic violence. She challenges person-centred, feminist, Milan, post-Milan and narrative therapists alike to acknowledge the ethical consequences of their form of therapy. For example, she comments that the 'main ethical dilemma for the narrative therapist ... would be how to work within the legal limitations on confidentiality ... and maintain engagement with the clients' (2001: 85).

In some senses, Hunter's article prepares the ground for the more radical article by Watson (2001). Watson provides a thoroughgoing critique of the notion that patriarchy is the fundamental cause of domestic violence and that only one form of practice flows from this analysis. He argues that the perspective that patriarchy causes domestic violence means that: 'poverty, substance abuse and compound disadvantage are dismissed' (2002: 92). Moreover, Watson suggests that this 'one-dimensional' understanding of domestic violence (which he regards as feminist-inspired) has 'silenced' other approaches. As a result, he calls for 'diversity' in the field: adequate research into the many forms of intervention.

Goldner (2001) herself provides a commentary upon Watson's article. In this (true to her own axiom of 'both/and') she both agrees with his call for diversity and also reasserts the value of the feminist perspective. The latter is the 'fundamental ethical and political framework', but once this is established 'there should be room for many voices and approaches to this grave and complex problem. Innovation should not be treason' (2001: 96).

'Cultural Competency' is the second of the year's themes, and here again, the *ANZJFT* was part of the debate.

Among other articles which considered cultural competency with specific cultural groups were a number that addressed the needs of Indian families (Dugsin, 2001; Wali, 2001). However, Khisty (2001) used her experience as an Indian woman in Australia to reflect upon how members from one culture connect to a 'host' culture. Khisty talks about the subtle personal changes that she underwent when she moved to Australia: 'Social dilemmas centred on whether one ought to relate with the "Australian politeness" or continuing in a way consistent with the typically Indian practice. Indians stopped behaving like Indians' (2001: 19). She gives an example of being invited out for a meal to another Indian's house: 'Should

one take a bottle of wine along?' (as in Australian culture) or not (as fits the relationship between host and guest within Indian culture)? Out of the discussions about how therapists can acknowledge and work with these differences, Khisty recommends a 'transcultural approach' because 'trans' implies being 'beyond' both (or indeed all) cultures. Her premise is that when individuals migrate, the process of change can be variable: but inevitable: 'in cultural transition ... all individuals are continually being transformed (2001: 23). Moreover, these families are themselves new and cannot be explained by any 'cultural stereotype'. Nor do the terms 'assimilation' or 'integration' match their experience (Rivett: 427).

Mark Rivett next isolates the theme 'Working with "neglected" client groups'.

There were, for instance, some articles that described a solution-focused approach to childhood disability (Coles, 2001) ... Bamberg *et al.* (2001) concentrated upon group therapy with parents of substance misusing adolescents. This team offer a structured programme of nine meetings in which a combination of education and therapy occurs. The 'topics' of the meetings ranged from 'encouraging self-management and responsibility' to 'individualised family strategies'. They comment that in this work there are 'three main steps' which are:

[to] ensure appropriate care for the parent ... [to] ensure working parental relationships ... [and] young people must be challenged and encouraged to establish responsible and reciprocal adult-adult relationships (Bamberg *et al.* 2001: 197).

Congratulations to the *ANZJFT* authors whose 2001 paper was selected for mention by Mark Rivett!

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