SAYING IT AND MEANING IT: FORGING AN ETHIC FOR FAMILY THERAPY*

by

Vincenzo F. DiNicola, M.Phil., M.D., Dip.Psych., F.R.C.P.(C)**

ABSTRACT

Ethical questions that arise from family therapy are addressed. The philosophical problem of knowing another person's experience or mind is posed in the context of working with families. This is particularly problematic with paradoxical techniques as they appear to state the truth of the family's experience in a way that goes beyond the factual, addressing implicit aspects of family interactions which are revealed to the therapist. Concepts are drawn from work on the nature of language and moral responsibility and related to new techniques in systemic family therapy. A distinction is drawn between the factual problem of the therapist "getting it right" and the ethical problem of "having a right" to point out implications and consequences of family interactions. The work of the Milan group on paradox and future questions is related to "counterfactuality". The liberating function of counterfactuality, operative in both techniques by offering new ways to frame the family situation and allowing new alternatives to be explored, is proposed as a resolution of this ethical problem.

"The dialectics of 'alternity', the genius of language for planned counterfacuality, are overwhelmingly positive and creative ... Language is the main instrument of man's refusal to accept the world as it is."

George Steiner (1984, p. 389)

"We give to each person the right to tell his own story in his own way."

Ignazio Silone (1949, p. 31, translated)

If I meet someone as an expert in human relations, must I tell him that? Is it correct to follow a line of questioning when my interlocuter does not understand what I am driving at, and does not appreciate what I will construct from his words? If I construct a hypothesis about the person in front of me and behave accordingly do I have an obligation to tell him what I am doing? Is it possible that in the course of a conversation, I will grasp someone else's experience in a way he has not? If so, may I then lead him to understand the meaning of his life, offering first to teach a language, new to him, to articulate his experience?

Harvard philosopher Stanley Cavell has posed the problem of how we come to know another's mind and the moral implications of how we state this knowledge in a series of highly personal and provocative essays (Cavell, 1976a). For me, this cuts to the heart of the problem of therapeutic sincerity and authenticity:

"...in the case of some mental phenomena, when you have twisted or covered your expressions far or long enough, or haven't found the words which give the phenomenon expression, I may know better than you how it is with you. I may respond even to the fact of your separateness from me (not to mention mine from you) more immediately than you.

"To know you are in pain is to acknowledge it, or to withhold the acknowledgement. -- I know your pain the way you do" (Cavell, 1976b, p. 266).

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* Revised version of a presentation to the Monday Case Conference, Allan Memorial Institute, Royal Victoria Hospital, McGill University, Montreal, Quebec, May 26, 1986. My title was inspired by Stanley Cavell (1976a). I wish to thank David Roy, Ph.D., Center for Bioethics, Clinical Research Institute, University of Montreal, for his critical dialogue and Mara Selvini Palazzoli, M.D., New Center for Family Studies, Milan, Italy, who provided valuable comments.

** Assistant Professor of Psychiatry, University of Ottawa; Director, Family Psychiatry Service, Royal Ottawa Hospital, 1145 Carling Avenue, Ottawa, Ontario, CANADA K1Z 7K4

Vignette 1. I am in front of a family. One of the parents poses a question about the outcome of their case. As it happens, I have recently reviewed the literature on this question, so that I have grasped all the available facts. However, I have just met them and I ask myself: Is this the correct time to reveal these facts? What am I really being asked? This family is a known "barracuda" that has already devoured some senior family therapists. In short, family therapy is a blood sport to them, diverting them from the pain of their life together. With these thoughts in mind, I compose the following answer: The prognosis for this condition is guarded at the best of times. (I am prepared to reveal that only one third of cases becomes stable with good management.) However, the situation does not allow me to predict that their case would fall into this better outcome group, and I believe their case has features that suggested the worst outcome. As I deliver this response, the parents become increasingly upset, while a beautific smile crosses the face of their daughter. The parents go into their well-rehearsed Mutt and Jeff routine, alternately pleading and taunting me to explain and justify my answer. I reply: "You're right, both of you, because you know, you have much more experience with your problem than I have with my solution. I mean, you're all much better at being patients than I am at being a doctor. And you have proven that, haven't you, I'm your third therapist, right?" Furious now, the father shouts, "Wait a minute here, are you trying to tell me you're not going to help us, you're just going to give up at our first meeting? We're that bad?" I reply that my experience is limited to much simpler cases. The other therapists who had failed were my teachers who had taught me all their tricks and I had no new ones. "Waddya mean no new tricks'?" the father says, "you can't think of something different to do? We were told you're a different kind of doctor!" "No, not really," I reply, "it's as hard for me to try to imagine being a different kind of doctor as it is for you to think about being a different kind of family."

Is it ethical to deliver a hopeless message? Will the family construe the message as a refusal to offer help or as a challenge to change? May we use our expert knowledge to interpret the facts and to skew our interpretation for an effect? In the last statement, is my message an ironic self-reference that will implode so that they will consider just that, being a "different kind of family"? The therapeutic basis of this strategy, where the therapist takes an extreme "one-down position" toward the family, was established by the Milan group. For example, see Chapter 16, "The Therapists Declare their Impotence without Blaming Anyone", in Selvini Palazzoli and associates (1978); and compare "Strategy 9: The Illusion of No Alternatives" in Chapter 5 of Madanes (1984).

Vignette 2. I have been consulted by a mother with two small children to work with her family. She is given to much introspection and self-doubts as to her adequacy as a mother. This is thrown into relief by the recent separation from her husband under shameful circumstances. The mother reveals this information to me in her mother tongue (which I speak poorly and the children don't understand) in order to shield them. She believes they don't know about these circumstances. Her husband is a chronic alcoholic, his business has failed, and he has impregnated a 16-year-old girl and abandoned his wife to marry the girl. It turns out that the girl aborted,

the relationship ended and he has sheepishly come back to his wife while ostensibly maintaining his own apartment. I have met several times with the mother and children already and have asked to see them all together including the father. I greet the father in the waiting room where he is gruff and standoffish. He has been drinking. Entering my office, the father notices a poster and turns to me accusingly: "How could you see children here? You call yourself a child psychiatrist? That poster is obscene, it's scary, and not fit for children." The poster is of a large Indian mask rendered in vivid primary colours and captioned "Sacred Circles". I am taken aback. When I recover, I laugh to myself thinking of the title of Eric Berne's (1972) book, What Do you Say After You Say Hello? After his hello, this is what I said: "I am trying to understand your concern about my poster. I guess you must really love your children to be so concerned about a poster. You must care for them so much that you are very careful about what they are exposed to, and you are not afraid to express this concern even to people like me who are supposed to know these things." Then turning to the mother, I said: "This is really very helpful because now I understand why he left home. He really wanted to protect his children. Isn't that right, sir? Your family is a sacred circle for you."

Is the intervention an honest one? Did I really believe he was concerned about his children and that he had left home to protect them? Is this an empathic reframing of the wounded child within him (to use Berne's terminology) that would allow him to move from concern for himself to concern for his children, which I modelled by being concerned about him, instead of responding defensively about my poster? A sound basis for such strategies can be found in the work of the Milan group (Selvini Palazzoli and associates, 1978) and Madanes (1980) who brings these pathological "protection rackets" out in the open.

When Words Fall Short

In my vignettes, I purposely left out diagnoses and outcome, in order to highlight the issue of how messages are delivered in therapy. The question that comes to mind first to many of us is whether the interventions "worked or not". They do work. Family therapists would not use such estoeric ways of talking if we did not get some feedback that they are useful. This is precisely why I want to raise these questions and why I have chosen examples from my own work. Have we become so outcome-oriented or "pragmatic" that we have lost sight of other things? Do we take part in a culture where what is accomplished (i.e., pragmatic outcome) is valued as more important than what is said? Or how it is said? Maranhão (1984), a cultural anthropologist, has made the point that thirty years ago, Bateson's group built a theory around the idea that double binds (i.e., ambiguous or mixed messages) drive people crazy and that that said something about American culture and how truth was valued at that time. The "social stock of knowledge" (Berger & Luckmann, 1967) now includes a variety of ways to "reframe" situations. Today, family therapists speak of positive binds, deliver oracular messages from fictional teams, consciously obfuscate the family's understanding of themselves, and speak in esoteric metaphors and deliver paradoxical prescriptions. What does this say about how we value speaking the truth today? Furthermore, Maranhão suggests that we cannot

simply make pragmatic choices. When we decide not to be truthful, we jettison a whole tradition of ethics based on knowing one's mind and speaking it sincerely with an intention that is not demonstrably different than appearances suggest.

This is a good question for ethics and for a cultural anthropologist to wield as a tool for understanding American cultural values. However, I would like to venture an answer to Maranhão and a defense of my own work. My answer comes from thinking about the nature of language and from working with some new tools in family therapy. Reading Steiner (1975, 1982, 1984) has led me to suspect that a good deal of the research related to language and affect in psychiatry is misguided. The following three examples which have received broad interest in different areas of psychiatry make my point:

1. Research on expressed emotion (EE), which shows that certain aspects of the way family members express themselves, i.e., hostility, critical remarks and intrusiveness, can be related to schizophrenic relapse (Kuipers, 1979).

2. Alexithymia, a concept coined by Sifneos (1972) to describe a cognitive-affective deficit in the experience and expression of emotion in psychosomatic patients; the idea that some people have "no words for feelings" has also been applied to psychotherapy to explain its failures (Krystal, 1982).

3. Leff's (1977) proposition of an affective hierarchy of world languages grew out of his observations on the International Pilot Study of Schizophrenia. According to Leff, the difficulty of translating the interview and rating scales into different languages suggests that some languages and cultures are more developed in the differentiation of emotions and the range of words to express them.

In each example, language differentiates people by putting them on a hierarchy based on whether they can articulate their emotions and do it without hurting themselves (as in the statement: alexithymia leads to somatization) or others (high EE leads to schizophrenic relapse). In his review of culture, affect and somatization, Kirmayer (1984) states, "Every language grants us eloquence when it is time to cry for help" (p. 159). According to Steiner (1975), each language and each individual's use of it represents an alternate version of humanity, and it is this very Babel that creates diversity and individuation. Every story is a version of not only what is, but of what might be. "Language is the main instrument of man's refusal to accept the world as it is," says Steiner (1984, p. 398). In numerous essays on language and politics, Steiner (1982) has shown that under dictatorship, language is subverted and atrophies: words fall short (Elkes, 1970). In a vigorous, open society rather than lying or betraying the truth, language is a view forward; in being counterfactual, it projects what Steiner (1975) calls "alternities of being".

The Milan model of systemic family therapy (Selvini Palazzoli and associates, 1978) has developed a specific technique of asking future questions (Penn, 1985) that takes advantage of this human propensity for imagining. What Steiner (1984) calls "counterfactuality" and "creative falsehood", Madanes (1980) calls "pretending". The Milan group uses this deliberately in their future questions. I believe that the Milan group's techniques of paradox and future questions are related to each other.

With paradoxical messages, the current and problematic truth of the family is stated in a way

that will implode it. A paradoxical message delivered in therapy is not a factual statement. It is an attempt to state not the explicit words and behaviour reported by the family or observed by the therapist but what is either implicitly meant or unknowingly revealed and grasped by the therapist. It is counterfactual. This differs from psychoanalytic interpretations which make conscious the unconscious and lead to insight. Paradoxical messages do not have to be understood or grasped on a conscious level to work. Two problems arise out of the discrepancy between the explicit and the implicit. First, there is the factual problem of whether the therapist got it right. Second, there is the ethical problem of whether the therapist has a right to make explicit the implicit and to reveal the unrevealed. Through paradoxical restatements, we make the family "exactly as responsible for the specific implications of [their] utterances as [they] are for their explicit factual claims" (Cavell, 1976c, p. 12). We confront them with their responsibility in a way they cannot avoid since it appears to bypass their defensive resistance, which is why these statements are both therapeutically powerful and ethically problematic.

With future questions, the family is encouraged to imagine alternatives -- future possible truths that are not constraining and will allow growth. The two techniques are linked. Just as paradox grows out of positive connotation of the symptom (i.e., defining something good that has been seen as bad, or counterfactuality), future questions invite the family to imagine things being different than they are (i.e., being what they are not, or again, counterfactuality). Paradoxical prescriptions deliver a "counterparadox" thus imploding the stalemate of the family game and future questions allow the family to experiment with alternatives. My argument is that it is this liberating function of counterfactuality operative in both paradoxical prescriptions and future questions that resolves the ethical problem of whether the therapist "has a right". But what if the message does not work therapeutically? Does the outcome determine the ethics of the strategy? No, it does not have the specificity of a "magic bullet". It's a gamble. Since we do not share the family's history, or the nuances of their words and meanings, we are constantly translating, which is a process of approximation (DiNicola, 1986). In this, the therapist undertakes the same responsibility and vulnerability as the family. Perelman (1980) makes a spirited defense of imprecision and sets out rules for the ethical use of "confused notions". For example, in legal philosophy, it is valuable to make some documents vague and general since all cases cannot be anticipated and jurists must establish and communicate principles applicable to future circumstances. Cavell (1976c) again has stated: "There can no more be some general procedure for securing that what one implies is appropriate than there can be for determining that what one says is true" (p. 12). It is tempting to recall Robert Kennedy's words, "Some people think of things as they are and ask, 'Why?' I dream of things as they might be and ask, 'Why not?'" Such statements proved to be as provocative to society at large as future questions are to families, and have attendant risks.

Ludwig Wittgensteing, the philosopher of words and silence who wrote, "All philosophy is a critique of

language" (1922, proposition 4.0031)[1] had a profound impact on psychology and linguistics with the publication of his major work, Tractatus Logico-Philosophicus (1922 in English). Wittgenstein held the fact/value distinction strongly. He did not propose, however, as the logical positivists (who established the philosophical groundwork of behaviour therapy) have read him, that this implied there is nothing outside of the world of demonstrable facts. His book is a rigorous attempt to outline the logical rules of factuals. However, Wittgenstein maintained that, "The sense of the world lies outside the world", (1922, 6.41) that is, outside the factual. "My work consists of two parts," he said about the Tractatus, "the one presented here plus all that I have not written. And it is precisely this second part that is the important one" (quoted by Janik & Toulmin, 1973, p. 192). Wittgenstein (1922) again: "What can be shown cannot be said", (4.1212). Wittgenstein left to aesthetics and to poetry the realm of ethics. Even a wordsmith like playwright Eugène Ionesco became skeptical of words: "There are no words for the deepest experience. The more I explain myself, the less I understand myself. Of course, not everything is unsayable in words, only the living truth" (quoted in Steiner, 1975, p. 185; emphasis added).

To conclude, following Wittgenstein, there are demonstrable things in life, such as questions about the outcome of therapy about which we must be very rigorous, and the behaviourists, taking this cue have been successful in doing. But when we pose questions about whether this is right, whether this is good or proper, there is no recourse to facts. And in this sense, ethics starts after the concluding proposition of Wittgenstein's (1922, 7.0) Tractatus,

> Whereof we cannot speak
> We must pass over in silence

About the counterfactual in Steiner's phrase, Wittgenstein is silent. The possible worlds of the future that a patient or a family imagines cannot be measured or demonstrated or judged. Contrary to the language research cited above, I believe as Silone said, that each person has the right to tell his own story in his own way. In response to that story, the unusual ways of communicating I have presented (paradox, future questions) are linked and sequenced moves in bringing the family to grasp its own unfinished and open-ended, evolving truth and not the therapist's personal truth. "Saying it and meaning it" implies acknowledging the patient's right to his story in both the things that are said and not said, as Cavell's (1976b) quote suggests ("To know you are in pain is to acknowledge it, or to withhold the acknowledgement", p. 266), and not the therapist's inflexible, narcissistic fixation on the purity of his own words cum mind.

[1] Wittgenstein's Tractatus is organized into a series of propositions numbered from 1 to 7 with lesser statements denoted by decimals.

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