Erschienen /published /publicado in/en:
Krohn W, G Küppers, H Nowotny (eds)(**1990**),
Self-organisation - Portrait of a Scientific Revolution.
Sociology of the Sciences. Yearbook 1990, Vol 14.
Dordrecht Boston London: Kluwer Academic Publ, pp. 128-142.

SYSTEMIC THERAPY - A PARTICULAR DRIFT BETWEEN SYSTEMS THEORY AND PSYCHOTHERAPY

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Abstract
As an applied science, psychotherapy has grounded its concepts and methods to a great extent upon the contemporary prevailing understandings of man and nature in the basic sciences. During the last decades it has incorporated as well the concepts of self-organization, cybernetics and systems theory and their epistemological and ontological consequences into its conceptual repertoire. This paper gives a succinct account of the historical development of paradigms in psychotherapy by reconstructing step-by-step the introduction of systemic thinking into this field. Then, it presents an outline for a Clinical Theory that intends to interrelate the different aspects entailed in clinical (psycho-therapeutic) work into a comprehensive whole that is sparing enough to provide for practicability. The paper ends by briefly presenting the results of first outcome studies made within this conceptual perspective that suggest its efficiency.

1. Historical remarks: the converging drift between psychotherapeutic practice and concepts of self-organization.

The beginnings of psychotherapy as an autonomous discipline, derived from both medicine and psychology, date back to the last quarter of the 19th century. Keeping step with its sources in medicine as an applied natural science in the Zeitgeist of the 19th century, personal suffering was conceived of as a symptomatic manifestation of inner psychic disorder, as a coming to the surface

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of not properly balanced psychic energies. It was assumed that if the process of intra-psychic binding of inborn energies did not succeed through adequate interconnections with the immediate environment, it would leave traumatic defects in personality which would then unconsciously interfere with the realization of conscious goals in adult life, thus eliciting suffering. The therapist's task was correspondingly conceived of as providing for a relational setting in which these "defects" could be analytically disclosed and worked through. Psychoanalysis and its corresponding psychopathology modelled itself within the paradigm of mechanics. Its main concern was with the inner functioning of the psychic apparatus (psychodynamics); its main purpose was to find ways to enter it through undermining its resistance against disclosure in order to make it analysable.

During the first quarter of the present century a partial shift of orientation took place. The experimental approach to learning had rendered a mechanistic vision of behaviour (conditioning) in terms of in- and outputs mediated by a not-yet-explainable mechanism (the organism). The concern with psychic processes was deemed mentalistic and of no interest for scientific inquiry. All that mattered was the observable, that is stimuli and reactions (= behaviours). The application of learning principles to healing began, though, only after the 2nd World War as large groups of veterans in need of psychological treatment overwhelmed existing treatment capacities. This new branch of therapy, behaviour therapy, claimed that, in comparison with psychoanalysis, it could considerably shorten the length of treatment and scientifically prove its effectiveness. Essentially, the psychopathological assumption of this approach was that suffering stems from either learned maladjusted behaviour or unlearned adjusted behaviour (1). Problematic behaviour was no longer regarded as a symptom of an abnormal apparatus, but as the illness itself; the application of the medical model to behavioural phenomena could thus be abandoned. The goal of this therapeutic orientation is, basically, to promote the learning of the missing and the unlearning of the inadequate.

By the time behaviour therapy began to expand, the 1950s, two other main orientations in psychotherapy stemming from practice appeared as well. The first, the so-called humanistic or phenomenological approach, gained importance during the 1960s; the second, family therapy, during the 1970s. In the work of Carl Rogers (2), a main exponent of the humanistic trend, a central consideration is paid to the person of the client in his or her totality. The psychopathological problems to be dealt with in therapy are regarded as an outcome of disturbing experiences that restrain personality from otherwise normal development (unfolding its possibilities). The work of the therapist consists of providing for an interpersonal setting which allows the client to experience him- or herself more fully and thus be freed from hindrances. For this to occur, the therapist needs to centre him- or herself in the client, refraining from alienating diagnostical and interventionist attitudes and behaviours. Helping to become fully a self-actualizing person is the goal of therapy.

As it may be inferred from the above, the short history of psychotherapy moves slowly from analogies from medicine and physics (mechanics) towards psychologically based models. Whereas with regard to psychopathology the location of its origins is shifted from the inner psychic to the interpersonal (learning, experiencing), with regard to therapy its proposals change from the notion of a socially abstinent analyst to that of an active participant in a social relationship. The next step in this course expands its focus to the social network of which the person is a part. It is taken by family therapy.

This new practice of psychotherapy emerges simultaneously at different locations in the USA and in Europe. It responds to pragmatic difficulties arising, especially, in the treatment of young schizophrenics and juvenile delinquents. As we learn from Harry Goolishian, one of the innovators of the time, the teams experimenting in what became later "family therapy" engaged in transgressing the limits of accepted standards (i.e. individual treatment) without having either support from their institutions or from other teams (3). These practitioners had observed that most young so-called schizophrenics would recover during inpatient treatment, but that many of them would come back with serious relapses after having been released to their families. More in terms of trying to understand the dynamics entailed in these relapses than of pretending to expand therapy into the family, they noticed regularities in intrafamilial behaviour which, if they could be triggered to change, would result in an increase in the probability for lasting recovery. This mainly pragmatic by-product of practitioners' inquiry led to an increasing repertoire of new therapeutic techniques that were, at first, not backed by consistent theoretical concepts. It was Gregory Bateson who, having engaged together with J. Haley, D.D. Jackson and others in trying to understand schizophrenic communication at a Veterans Administration Hospital at Palo Alto, California, began influencing theoretically the field by bringing in cybernetics as a means to describe and explain the functioning of families in terms of complex, circularly organized behavioural patterns. The notion of self-regulative feed-back loops that maintain homeostatical constancy in families became central. This work was continued at the Mental Research Institute in Palo Alto by Paul Watzlawick and colleagues (4).

From this point of view, the family is seen as an open system committed to conserve its structure stable in face of environmental strains. Symptoms are conceptualized as self-regulative mechanisms maintaining the system's homeostasis, that is, as fluctuation-reducing, negative feed-backs. Symptoms are thus implicitly functional. That they are nevertheless termed dysfunctional results obviously out of deviance from normal expectation about how family members should operate. Suffering stems from the impossibility of stopping such "dysfunctional" processes. Correspondingly, therapy is modelled on the need of re-regulating the system's functioning through interventions from the outside. Depending on the orientation of the therapist, the goals of therapy vary between restructuring the family, interrupting their dysfunctional communication patterns, and logically tackling their inappropriate world views (5). The development in family therapy reached its peak in 1978 in terms of field-wide acknowledgement, as a Milan team reported their impressively effective work with families of schizophrenic youngsters (6). Their concepts integrate the thoughts of cyberneticians and communication and systems theorists with practice into a coherent and effectively applicable form. In 1980 the Swiss psychiatrist Gottlieb Guntern proclaimed finally The Copernican Revolution in Psychotherapy, meaning a radical change from an analytical paradigm based on Newton's physics to a systemic one relying on modern systems theory and related disciplines (7).

During the late 1970s an increasing interest in systems theory, self-organization and their epistemological consequences spread into the field. Although many of the leading family therapists adhered to the terms of ad hoc explanations of their impressive therapeutic success (mostly in terms of rather simplistic analogies to systems dynamics, e.g. mobiles), a few others, in search for more coherent explanations, made a notorious shift towards the work of Prigogine, Jantsch, von Foerster, Maruyama, and other scientists involved in studying self-organizing systems(8). The historical

accomplishment of family therapy is to have drawn attention to notions like patterns and processes instead of elements and states, and to complexity, interpersonal dynamics and circularity instead of traits, intrapersonal dynamics and lineal causality. Systemic therapy adds to this, essentially, a shift in orientation from objectivism to constructivism. Its implies thus an epistemological shift.

2. Systemic therapy

During an International Conference taking place in 1981 in Zurich, Paul Dell thoroughly tackled the theoretical relevance of almost all that had become indispensable as a foundation of family therapy, e.g. the notions of homeostasis, information, open system, dysfunctionality, strategic and paradoxical intervention, etc. (9). A little later, the 1982 issue of the journal Family Process included a few papers that would initiate a momentous shift in theory and practice (10). The advanced propositions challenged therapy theory right at its base. They were: structure-determinism and operational closure of all biological and thus cognitive and social systems with its epistemological and ontological consequences.

In one of these papers, Paul Dell calls attention to the unsuitability of a therapy theory based upon homeostasis and stability that fails to explain its main goal: change. Drawing on Maturana's writings he proposes to do away with the notion of a family as an open system embedded in larger systems that determine it. Instead, he proposes to think of family in terms of a structure- determined entity that operates in closure, i.e. only with its own states, and that therefore may not be determined from the outside. From this position, the notion of pathology becomes obsolete, since all systems are at any time functioning at their best. The proposition of operational closure poses a tremendous challenge to therapy theory, since its right to exist is grounded precisely on the possibility of deliberately changing (healing) individuals and groups. Bradford Keeney, following mainly Bateson's thinking, calls the attention of the therapist to the epistemological understanding that all knowledge, and thus also all knowledge concerning the functioning of families and of therapists is bound to distinctions drawn in the cognitive domain of observers, and hence not to an independent, transcendental reality. Since this is the case, the therapist is no longer an objective authority entitled to make decisions about his or her clients. Thus, ethics rather than objectivity should become the foundation of therapy, and therapy should be understood as applied epistemology. From this it follows that therapy may not be understood adequately if conceptualized only in terms of pragmatic utility. It needs to be implemented in a realm defined by the complementarity of pragmatics and aesthetics, that is of technological craftsmanship and poetical artistry. Finally, Steve de Shazer contends that clients by joining a therapist configure together with him or her a common social system that becomes the relevant entity. The therapist may no longer be seen as an intervening agent from the outside. From this point of view, he contends that a theory of therapy should deal with the specific mode of cooperation between clients and therapist and lay aside such traditional notions of psychotherapy as "power" (on the part of the intervening therapist) and "resistance" (on the part of the client). The assumption that clients ultimately always cooperate with the therapist leads the latter to assume responsibility for behaving in a manner that is likely to meet the specific ways of cooperating of each client-system. This notion reflects more adequately the self-referentiality of the therapy system; it also defines a more ethical setting by allowing the therapist to de-vise procedures which are better fitting to the client and thus less painful and time-wasting, hence more efficient.

The 1980s are the era of systemic therapy. As a further development out of family therapy it relates to its origins in an equivalent manner as does 1st to 2nd order cybernetics (11). Its theoretical background has incorporated especially Maturana's theories of autopoiesis, cognition and sociability, but also von Foerster's cybernetics of observing, von Glaserfeld's radical constructivism, and Luhmann's sociological systems theory (12). Within this frame, the notion of systemic therapy may be reserved for the therapeutic practice that takes place whenever the therapist reflects upon and guides his or her activities from a systemic point of view. That is, whenever he or she conceives him- or herself as an active, constituting member of a social system - the therapy system - in which he or she conjointly with his or her clients bring forth a therapeutic reality that is propitious for eliciting change. Since theoreticians of systemic therapy have not yet attained a consensus with regard to their subject (apparently an unavoidable aspect of discourse in psychotherapy), the following restricts itself to the position of our Hamburg team (13). It presents an outline for a Clinical Theory based on systemic thinking that comprises the relevant literature and orders it into a comprehensive and yet condensed, thus workable unity (14).

3. Outline for a clinical theory

A systemically conceived of, comprehensive theory of psycho-social healing-practices needs to entail coherently the following: 1) a definition of the "systemic", that is a demarcation of the domain of knowledge to which it pertains; 2) a description of social systems that is compatible with 1); 3) a specification of problem-systems, that is, of social systems centred on a problem; 4) the formulation of criteria of evaluation for therapy that are congruent with 1); and 5) a methodological solution to the problem of therapy and its evaluation in accordance with 1) - 4).

3.1. A definition of "systemic"

The term "systemic" has been used in the field of therapy in a very loose manner. In fact, it has traditionally served mainly as a distinguishing mark from "non-systemic" therapies but without a consensually accepted meaning. For the purposes of this paper, the well-established adjective "systemic" will be specified in terms that bindingly delimit the entailed domain of discourse (15). In a first gross approach, "systemic" is defined as the specification of a general method of thought, indeed a "way of seeing" (16) concerned with systems. In order to make this overall definition more precise, six propositions seem to suffice which, in the frame of this publication, do not require further explanation as they refer to the core of thinking entailed in this book, e.g. bio-epistemology, 2nd order cybernetics, Self-organisation and modern systems theory. They are:

(1) Everything said is said by an observer (17);
(2) an observer is a languaging living being who draws distinction in language and brings thus objects into existence;
(3) everything said is brought forth by observers in conversation with other observers;
(4) it follows, that reality becomes realities-in-parenthesis, that is, arguments in communication;
(5) and, since a system is a unity that was brought forth by an observer who regards it as a composite unity (i.e. composed of elements and their interrelations);
(6) "systemic" refers to a "way of seeing" concerned with systems (as specified in (5)).

Propositions (2) and (3) define the terms included in the universal proposition (1): the observer and

what is said. Proposition (4) follows from (1-3). Proposition (5) specifies the term "system" in accordance with the foregoing propositions, and finally (6) follows from (1-5) substantiating the general definition of "systemic" given above. This set of propositions intend to follow closely what Humberto Maturana has called the explanatory path of objectivity-in-parenthesis (18). By this is meant that if the observer accepts that he or she is a human living system, he or she must also accept to be inescapably embedded in the biological phenomena that constitutes him or her as an observer. In this sense, an observer cannot do anything else but constantly realize his or her condition as a living system in-language. As an autopoietically organized unity, the living system is described in modern biology as a structure-determined, operationally closed and thus autonomous system. It follows that an observer has no operational basis to make any statement or claim about objects, entities, or relations as if they existed independently of what he or she does. Consequently, the notion of a transcendental reality becomes irrelevant, and objectivity, in terms of an accurate representation of the world, becomes biologically unattainable. It is the observer who constitutes existence through the operations of distinction he or she makes while living a domain of languaged coexistence. Observers realize and conserve their basic organization as human living systems as long as they conserve adaptation (compatibility) with their environment. The organism, as a totality, does not interact with its environment; it may do so only through its components (e.g. receptor cells). Occurrences in the environment may have a perturbing effect upon components of the organism and therefore may trigger their functioning, but they never determine the course of the reaction of the organism which is at all times determined by its own structure. An observer who focusses on the organism in its process of living may chose to speak of "instructive interactions" (i.e. determining inputs). By doing that, the observer overlooks though deliberately or inadvertedly the structure determinism of the organism. No environmental agent may purposively determine the behaviour of a living being. However, a thorough understanding of the structure of a living being may enable an external subject to provoke in it expected reactions with some degree of predictability. For this, he or she must either "properly" trigger its functioning (within the range delimited by its structure) or configure marginal conditions in which expected reactions become probable. In both cases, even though the behaviour of the living being may appear to an observer as "controlled" by these circumstances, it is the affected living being which determines the course of its reactions.

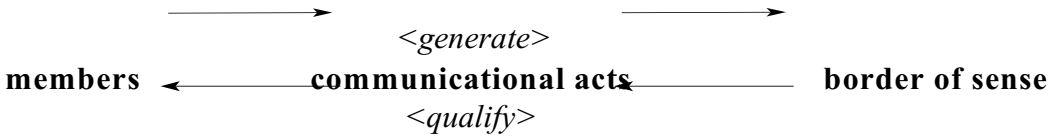
3.2. Social systems

Presently, two differing conceptions of the social system dominate the domain of systemic therapy. One of them is more attached to biological thinking, the other to sociological theory. Biologically grounded explanations define social systems as composed of (bodily) human beings and their interrelations (structure couplings). Social interaction occurs embodied in the organism of the participants (19). From a sociological point of view, Luhmann (20) defines social systems as composed of communicational actions (elements) and the adhering of these elements to each other (relations). In the sense that they produce their own elements (communications), social systems are understood as autopoietic; the human individual is displaced into the environment of the social system. Being social systems composed of sequences of events, they have no spatial existence, they may only be distinguished (inferred) by an observer as temporary unities. In order to make this inference the observer orders the observed events along a particular criterion of continuity: "sense" (German: Sinn). Sense implies a phenomenological process of selection under conditions of

complexity that allows discerning which events pertain to a certain communicational sequence and which do not. In other words, it allows ordering whatever "makes sense" as belonging together, and thus to sort out all other social actions. Sense delimits the boundaries of a social system (border of sense). From the perspective of the participants, sense is what enables them to keep pace in communication (to adhere adequately), and what confers structure to a particular communicational network (through developing expectations).

With respect to therapy both of these positions pose conceptual and pragmatic difficulties in terms of modelling. If the clients are seen as biological individuals, the therapist's task consists of properly perturbing them as components of the system in order to trigger the system to change. For this to be accomplished, the therapist needs to have attained a deep understanding of the clients in all their individual and social complexity. But, to understand deeply the client(s) demands engaging in extensive interactions with them (besides having to resolve the epistemological problem entailed in this). The therapist is thus confronted with the difficult task of duly interacting without getting entangled in precisely those behavioural patterns which he or she seeks to change, that is, without becoming conditioned by the client-system. On the other hand, the understanding of social systems as mere sociological abstractions composed of communicational networks runs against the therapist's perception of full-sized individuals sitting in front of him or her. Hence, both concepts exceed the cognitive skills of the therapist. Because of this, the following attempts to facilitate the therapist's understanding of his or her task by supplying him or her with a conceptualization of the social system that applies more adequately to therapy. This needs to be a) coherently systemic (see above) and yet b) practicably applicable to therapy, and it should additionally take into account that c) the therapist works in face of flesh-and-blood individuals, in d) a conversational, social process that should therefore be formulated in terms of the social domain.

This we have attempted by means of a concept that is concrete enough to fit with the therapist's perceptions, and abstract enough to suit the diction of social discourse: the concept of "member" (21). By a member we understand a social operator who performs at least one operation that is followed (adhered) by the operation of another entity of the same class (22). A member is always embodied by a human being, it is thus able of acting and cognizing, but its definition does not overlap with that of its "generator", a human being. The social operator "member" is generated and conserved by a human being whose structure is, in turn, to some extent modulated by the operations entailed in all the memberships it produces. "Member" pertains inseparably to a membership in a particular social system; its definition considers only the (communicational) operations fulfilled while being realized. In this sense, members, communicational acts, and the border of sense of a specific social system mutually generate and qualify each other and thus reciprocally condition the existence of one another. This is illustrated in the following figure:



Although the concept of member resembles at first sight that of the role-player, both concepts belong notably to different domains of discourse and should be handled distinctively: Whereas role-player is embedded in role-theory and thus related to structuralist and normative notions, member

is defined as an entity that is inseparably connected to a particular social system by co-specifying its dynamics; it pertains therefore genuinely to the domain of (social) systems theory. In the context of membership, the notion of social role refers to a generalized description of a behavioural programme as it is fulfilled by a member. As an entity that is distinguished in the social realm by reference to another member, this concept helps as well to refrain from unduly individualisation, generalisation and reification, and thus to maintain a clear "logical book-keeping" between the entity and its domain of existence (23).

With respect to the conceptualization of therapy in systemic terms, the concept of member delivers one main advantage over related concepts: The goal of therapy needs not to be conceived of in terms of having either to understand "deeply" and/or to change a human being, a person; instead it suffices to conceive it in terms of adequately triggering the dissolution of membership in a problem-system.

3.3. The problem-system

The utility of the above conceptualization of components of social systems becomes more apparent while defining the "problem-system", being it a specific social system centred on a "problem". It is claimed that a problem of living may only become a matter of social concern if it is somehow uttered and communicationally adhered. A sequence of communicational actions must have established itself that is valued either by the participants or by a non-involved observer as unpleasant, painful, in short, as in need to change (disappear). In this sense, it may be contended that a problem is always constituted through communication, that is, through a social system that emerges while communicationally dealing with a disliked theme. Such a social system may be termed a "problem-system" (24).

In order to explain the coming about of a problem-system it is required, as it applies to all other social systems (see above), to consider simultaneously two domains of discourse, being careful not to infringe on the logical book-keeping: The domains of the generators (human beings) and of the operators (members) entailed in the emergence of this system. At the level of the participating "generators" the fulfilment of two conditions seem to suffice: 1) At least one of them must negate, to some extent, the right of another to generate an adequate operator "member" in a specific interaction (25); and 2) at least another one must insist in trying to change this evaluation in his or her terms. If this pattern stabilizes itself, a social system emerges that, at the level of its members, functions just as well as any other social system (otherwise it would dissolve). But, because of the emotional effects this communication has on the persons who generate the members of the system, either through the experience of being negated as a legitimate equal or through comparison with other less troublesome memberships generated by the same person, it is bound to elicit suffering and thus give rise to evaluation as a problem. However, probably precisely because the participating persons wish to quickly (dis-)solve the problem, a great deal of interactions (or variations on the same theme) occur that are bound to keep it going (26).

The concept of the problem-system provides for a number of theoretical and pragmatic advantages in therapy. They may be summarized as follows: 1) it is coherently systemic; 2) it does away with the necessity to postulate "psychopathology", "family dysfunctionality", etc., since a problem-system

does not differ fundamentally from any other social system; 3) it allows defining the goal of therapy in terms of the dissolution of the problem-system instead of the repairing or re-teaching of a psychic apparatus or a family structure; 4) it allows the therapist to work decidedly with the "resources" of the clients, since they embody many other memberships and dispose thus at any moment of a behavioural repertoire that can be triggered to do "something else" instead of "more of the same"; and 5) it frees the therapist from having to be an expert in matters of life, since all he or she needs to do is to provide for favourable conditions for a shift in the preferences of his or her clients. In sum, this concept liberates therapist and clients from having to engage in the traditional game of negatively connoting each other (diagnosing, treating, resisting, etc.) while trying to find and give help.

3.4. Criteria of evaluation

The acceptance of the above advanced systemic premisses leads basically away from the traditionally acknowledged criterion of therapy evaluation, i.e. the assessment of its efficiency in terms of having "objectively" removed suffering through the application of a suitable treatment. A systemically founded Clinical Theory must therefore develop criteria for evaluation that are coherent with its premises. Faced with this problem in the domain of science, constructivists have re-oriented their understanding of science from the search for truth towards the utility of knowledge, that is to the viability of scientific solutions . Unable to validate scientific knowledge against an independent reality, all scientific utterances necessarily fall back upon their authors and their validity depends on the attained plausibility within the scientific community. For this to occur, knowledge needs to prove useful or viable, that is, it must allow orienting actions effectively without running into hindrances. Knowledge may not ever "match" reality, but it serves to surpass its constraints through "fitting" with them (27).

The concentration on viability in terms of effective operationality as the main criterion of validity for a therapeutic orientation proves to a great extent coherent with the systemic view. It disregards though, in the last consequence, the central importance of the observer as the source of all knowledge, since the cause of viability is posed ultimately on the "treated". Conversely, within the path of objectivity-in-parenthesis it is the observer who constitutes existence through languaging, and who therefore may at any time reflect about this process of reality construction. Insofar as the observer has this capability of reflecting he or she takes unavoidably responsibility for the world he or she lives. Following this line of thought, the consideration of viability as the sole criterion of acceptability for a method appears insufficient; it should be complemented by criteria that bind the activities of the performer to his or her personal responsibility. Otherwise the discourse is in danger of falling back into objectivism.

Taking into account that therapy is a social undertaking at the core of human interests: the overcoming of suffering that permits no "trivialisation" (28), and with the intent of modelling it without abandoning the path of objectivity-in-parenthesis, we propose to complement the criterion of utility (viability) with two further criteria: beauty and humanity (29). In this sense, for a therapeutic process to be valued as acceptable it must not only prove effective in terms of solving a problem by whatever means, it must also meet aesthetic and ethical considerations. These additional criteria allow therapists and/or therapy theoreticians to keep in touch with the systemic

premises without having to dispense with the personal responsibility entailed in therapeutic processes. Since these essentially subjective considerations escape nomological ruling, they refer inescapably back to their proponents. The observer (theoretician and practitioner) who is willing to abide by these criteria must therefore make explicit how far his or her choices regarding theory and methodology as well as their application will render a beautiful, human and useful therapeutic process. In Maturana's words: The knowledge of knowledge obliges (30).

3.5. Methodology of therapy

In the light of all that has been stated above, therapy may be formally defined as the conversational process occurring while generating, conserving, realizing, and terminating a social system - the therapy system - under the following conditions: 1) At least one of the persons involved must define his or her membership in it as that of the therapist; 2) at least another one must define his or her membership accordingly as that of the client (customer), that is by making out of his or her participation as a member of a problem-system the subject matter of the conversation with the therapist; and 3) their interactions must be im- or explicitly limited in time. If these conditions are fulfilled all what can happen, from the point of view of an observer who acknowledges them as such, is therapy. All other conditions that might be imposed upon therapy, especially in normative terms, are not substantial since they may vary from place to place and from time to time.

If this formal definition of therapy is to serve the therapist as an orientation for defining him- or herself as such in terms of attitudes and activities bound to elicit effective cooperation with his or her clients, it needs to be operationalised. A number of alternative options have traditionally been used for this purpose. They are: 1) The effects of therapy; 2) the interactions between therapist and client; 3) the duration of therapy; 4) the structure of the client; and 5) the structure of the therapist. Because of the following reasons we have opted for the latter: For therapy to be operationalised in terms of its success it must be assumed that clients may be deliberately "instructed" or determined (see above); the utilization of the interactions between therapists and clients requires their standardization and thus an unnecessary a priori restriction of the scope of possible actions in therapy; the choice of time duration as the base for a methodological decision proves senseless prior to each therapy; the assessment of the client's structure, for instance, in terms of severity of illness or of adequacy for therapy (predictability of success that outweighs the efforts) is grounded on the assumption of objectivity (without parenthesis) and, in addition, it dispenses with any ethical substantiation. Having dismissed all these options, what is left for the purpose of outlining a method is the structure of the therapist's membership.

The methodological definition of the therapist's structure may be attained by proposing a more or less generalized program of actions, that is, by defining the role of the therapist. This definition needs to take into account both that 1) whatever the therapist does during therapy is to be done "as a therapist" and 2) that the therapist is embodied by a person in the only possible manner this person can do it. The definition of the therapist needs therefore to be both task- and person-oriented. Furthermore, therapeutic activities should be conceptualized according to the criteria stated above, i.e. in terms of their expected utility (goal-orientation: dissolution of the problem-system), beauty of form (choice of interactional manners), and humanity of attitude (respectful acceptance of the client). This we have accomplished elsewhere by formulating 10 + 1 guidelines or guide-questions

for the therapist which concisely summarize these lines of thought in a manner that has proven helpful both in terms of orienting the activity of the therapist and of providing a frame of reference for supervision (31). Since they primarily pertain to the practice of therapy, these guidelines will not to be treated here in detail.

4. Outcome evaluation

In the field of family therapy, as in all other fields of psycho-social therapy, there is a continuing debate going on regarding the efficiency of the applied methods. The contentions of review articles written by prominent family therapy researchers in the handbooks of the last decade point to an overall empirical utility of family therapy (32). On the other hand, authors concerned mainly with the observance of the rules of research methodology (at times of "methodolatry" or the tendency to let research methods dictate what are proper data) conclude that family therapy is still far from having soundly proved its utility (33). They claim that most of the positive outcome results stem from either clinical samples (as opposed to a research design providing for matched control groups, pre- and post measurements, placebo groups etc.) or inadequate methodology of appraisal. Further, they claim that these positive results are contaminated with those of other therapy orientations not properly sorted out from the researched samples. In sum, the discourse about therapy outcome seems to cling to the traditional dispute between clinicians and researchers of the field. Whereas clinicians have actually admitted family therapy into their field by supporting a number of training institutions and professional associations all over the world, researchers remain sceptical about the efficiency of this method.

Interestingly enough, in spite of this discussion, research shows that psychotherapy is, regardless of the applied method, overall of help, that is, of more help than when it does not occur (34). Obviously, this means that, in the long run, all methods are helpful if they meet, at least to some extent, the expectations and needs of the client(s). Insofar, a therapy method that claims effectiveness is supposed to at least beat the rate of so-called spontaneous remission (35). Besides that, there is some evidence that even a one-session-counselling may be all what is needed (36). Taking these aspects (among others) into consideration it may be followed that therapy should be practised within the margins marked by doing too much (too long a time, too much intervention, too much technology, etc.) and doing too little (too little care, too little orientation on the client's needs, too little optimism, etc.).

With regard to "systemic therapy", understood as an orientation that appeared first in the 1980s (see above), there are still few reports of outcome. This orientation has been more preoccupied with clearing out its own theoretical background than with trying to assert empirically its efficiency. Most of the reported assessments were obtained clinically and not by means of traditional methodology. The Brief Family Therapy Centre in Milwaukee reports, for instance, improvement rates of about 80% after an average of 4-5 sessions as assessed by follow-up phone calls (Steve de Shazer, personal communication 1988). These results coincide with those of other institutions of the same or similar affiliation.

In our own studies at the out-patient clinic of the Department of Child and Juvenile Psychiatry at the University of Hamburg we have come to similar results. Since 1982 we have been developing a

mode of questioning outcome in accordance with our understanding of systemic thinking and with the criteria of validation expressed above. It concentrates on the appreciation given by the clients regarding three aspects of therapy: utility, beauty of form (fitting of therapist's behaviour to the client's expectations) and respect in attitude towards the client(s). A first major result was obtained in a mail follow-up of all clients that attended therapy sessions with four systemic oriented therapists in 1983 (42% return rate). It disposes in favour of optimism: 75% of the clients (mostly families) report by the time of questioning (2-4 years after finishing consultation) that the child that had presented the problem is doing well; they attribute this clearly, at least to some extent, to the conversations held with us. The most impressive result is, however, that this outcome was obtained, regardless of the kind of presented problem, after an average of 2,75 sessions (total range: 1-12 sessions).

If these results are substantiated by a current follow-up study of all clients treated between 1984-6 (a first account of 40% of the answers does so) it may be plausibly concluded that a systemic understanding of therapy proves not only to consider duly the autonomy of human beings in theoretical but also in pragmatic terms by efficiently helping solve problems with the least possible perturbation. As such, it actualizes the criteria of utility, beauty, and respect qualifying them as adequate conditions of therapy. Additionally, it helps overcome the dilemma sketched out at the beginning of this paper, i.e. of having to choose as a theoretician and/or practitioner of therapy between complying with the rules of (uni-versal) science and enacting personal autonomy as a viable means towards the construction of liberating (multi-versical) realities.

NOTES AND REFERENCES

1. See, for example: H.J.Eysenck, S.Rachman, *The Causes and Cures of Neuroses*, London: Routledge and Kegan Paul, 1965; Ch. Kraiker (ed.), *Handbuch der Verhaltenstherapie*, Munich: Kindler, 1974.

2. C.R.Rogers, *Client-centred Therapy*, Boston: Houghton- Mifflin, 1951; *On Becoming a Person*, London: Constable, 1961.

3. H.Goolishian, workshop in Hamburg, 1986. See also: H.Anderson et al., 'The Galveston Family Institute: Some personal and historical perspectives', in: D.Efron (ed.), *Journeys: Expansion of Strategic-Systemic Therapies*, New York: Brunner/Mazel, 1986; G.Bateson et al., *Schizophrenie und Familie*, Frankfurt: Suhrkamp 1969; L. Hoffman, *Foundations of Family Therapy*, New York: Basic Books, 1981.

4. G. Bateson et al., *op.cit*., 1969, note 3. See also: P. Watzlawick, J.H.Beavin, D.D.Jackson, *Pragmatics of Human Communication*, New York: Norton, 1967.

5. C. Sluzki (cf. *Family Process* 22: 469-476, 1983) points out that the three predominant approaches to family therapy focus primarily at either process, structure or world view of the families. The structural-strategic approach intervenes to restore a (normative) "healthy" family structure, e.g. S. Minuchin, *Families and Family Therapy*, Harvard University Press, 1974; J.

Haley, *Problem-Solving Therapy*, San Francisco: Jossey-Bass, 1976. The interactional, process-oriented approach points at interrupting "dysfunctional" communicational patterns, e.g. P.Watzlawick, J.Weakland, R.Fisch, *Change: Principles of problem formation and problem resolution*, New York: Norton, 1974. The approach that concentrates on changing the world-views of families (epistemes) stems especially from the work in Milan, see note 6.

6. M. Selvini-Palazzoli et al., *Paradox and Counterparadox*, New York: Aronson, 1978. See also: Selvini et al., 'Hypothesizing -Circularity - Neutrality: Three guidelines for the conductor of the session', *Family Process* 19: 3-18, 1980.

7. G. Guntern, 'Die kopernikanische Revolution in der Psychotherapie: Der Wandel vom psychoanalytischen zum systemischen Paradigma', *Familiendynamik* 5: 2-41, 1980.

8. For example: P.F.Dell, H.A.Goolishian, Ordnung durch Fluktuation: Eine evolutionaere Epistemologie fuer menschliche Systeme', *Familiendynamik* 6: 104-122, 1981.

9. P.F.Dell, 'From systemic to clinical epistemology', in: *Zusammenhaenge* 3, Institut fuer Ehe und Familie, Zurich, 1982.

10. *Family Process* 21, 1982: P.F. Dell, 'Beyond Homeostasis: Toward a concept of coherence', pp. 21-41; B.F.Keeney, 'What is an epistemology of family therapy?', pp.153-168; B.F.Keeney, D.H.Sprenkle, 'Ecosystemic Epistemology: Critical implications for the aesthetics and pragmatics of family therapy', pp. 1-19; and S. de Shazer, 'Some conceptual distinctions are more useful than others', pp. 71-84. Regarding the quest of pragmatics or aesthetics in therapy, see also: H.Stierlin, 'Family Therapy - A science or an art?', *Family Process* 22: 469-476, 1983; K.Ludewig, R. Schwarz, H.Kowerk, 'Systemische Therapie mit Familien von "psychotischen" Jugendlichen', F*amiliendynamik* 9: 108-125, 1984.

11. H. von Foerster, *Sicht und Einsicht*, Braunschweig: Vieweg, 1985. With regard to therapy, see: L. Hoffman, 'Beyond Power and Control: Toward a "second-order" family systems therapy', *Family Systems Medicine* 3: 381-396, 1985.

12. H.R.Maturana, *Erkennen: Die Organisation und Verkoerperung von Wirklichkeit*, Braunschweig: Vieweg, 1982; H.R.Maturana,'Reality: The search for objectivity or the quest for a compelling argument', *Irish Journal of Psychology* 9: 25-82, 1988; H.R.Maturana, F.J.Varela, *The Tree of Knowledge,* Boston: New Science Library, 1987; H.v.Foerster, op.cit., 1985, note 11; E.von Glasersfeld, *Wissen, Sprache und Wirklichkeit*, Braunschweig: Vieweg, 1987; N. Luhmann, *Soziale Systeme*, Frankfurt: Suhrkamp, 1984.

13. The notions summarized here have been extensively elaborated in: K. Ludewig, '10+1 Leitsatze bzw. Leitfragen', *Z. systemische Therapie* 5: 178-191, 1987, (engl. in: J. Hargens (ed.), *Systemic Therapy. A European Perspective*, Broadstairs: Borgmann, 1989); 'Nutzen, Schoenheit, Respekt -Drei Grundkategorien fuer die Evaluation von Therapien, *System Familie* 1: 103-114, 1988a; 'Problem - "Bindeglied" klinischer Systeme', in L. Reiter et al. (eds.), *Von der Familientherapie zur systemischen Perspektive*, Berlin: Springer, 1988b.

14. The presented concepts are related theoretically to those of the Galveston Family Institute, cf. H.A.Goolishian, H. Anderson, 'Menschliche Systeme. Vor welche Probleme sie uns stellen und wie wir mit ihnen arbeiten' in L. Reiter et al.(eds.), *op. cit*., 1988, note 13; and pragmatically to those of the Brief Family Therapy Centre in Milwaukee, cf. S. de Shazer, *Keys to Solution in Brief Therapy*, New York: Norton, 1985, and *Clues: Investigating Solutions in Brief Therapy*, New York: Norton 1988. They differ, though, from them in terms of focal point. Whereas Goolishian centers his interest in understanding meaning systems and in dialogue, and de Shazer focuses on the dynamics of rapid change through fitting interventions, our propositions concentrate on defining the therapist in a manner that is generally propitious for triggering rapid change by means of dialogue.

15. Ludewig, *op.cit.*, 1987, note 13.

16. F.Steier, 'On cybernetics as reflexive understanding', Continuing the Conversation: A Newsletter of Ideas in Cybernetics 12: 7-8, 1988.

17. Statements (1) till (5) are closely derived from propositions advanced by Maturana and Varela, *op.cit*., 1987, note 12.

18. Maturana, *op.cit*., 1988, note 12.

19. H.R.Maturana, 'Biologie der Sozialitaet', *Delfin* 5: 6-14,1985.

20. Luhmann, *op.cit*., 1984, note 12.

21. Ludewig, *op.cit.*, 1988b, note 13.

22. This notion is to some extent related to that of the individual as discussed by P. Hejl, see, for example, 'Zum Begriff des Individuums' in G.Schiepek (ed.), *Systeme erkennen Systeme*, Munich: Psychologie Verlags Union, 1987.

23. Maturana and Varela, *op.cit.*, 1987, note 12. With respect to the domain of therapy, see: K.Ludewig, 'Von Familien, Therapeuten und Beschreibungen. Vorschlaege zur Einhaltung der logischen Buchhaltung', *Familiendynamik* 11: 16-28, 1986.

24. Ludewig, *op.cit.*, 1988b, note 13. Somewhat similar notions may be found in Goolishian and Anderson, *op.cit.*, 1988, note 14, and in Luhmann, *op.cit.*, 1984, ch. 9, note 12.

25. Here we follow essentially Maturana, *op.cit.*, 1988, note 12, and C.L. Mendez, F. Coddou, H.R. Maturana, 'The bringing forth of pathology', *Irish Journal of Psychology* 9: 144-172, 1988.

26. The intended solution becomes the problem. See: Watzlawick et al., *op.cit.*, 1974, note 5.

27. S.J.Schmidt (ed.), *Der Diskurs des Radikalen Konstruktivismus*, Frankfurt: Suhrkamp, 1987.

28. H. von Foerster, *op.cit*., 1985, note 11. He points with this notion to the process involved in functionalizing the human being as if it were a "trivial machine", i.e. a non selfreferential device determined by inputs.

29. Ludewig, *op.cit*., 1988a, note 13.

30. Maturana and Varela, *op.cit.*, 1987, note 12. See also: 'Hinter den Kulissen der Kognition. Mit Humberto Maturana im Gespraech', *Familiendynamik* 13: 165-170, 1988.

31. Ludewig, *op.cit*., 1987, note 13.

32. See, for instance: A.S. Gurman and D.P.Kniskern, 'Research on Marital and Family Therapy: Progress, perspectives, and prospect' in S.Garfield and A.Bergin (eds.), *Handbook of Psychotherapy and Behavioral Change*, New York: Wiley, 1978; A.S.Gurman and D.P. Kniskern (eds.), *Handbook of Family Therapy*, New York: Brunner/Mazel, 1981; T. Jacob (ed.), *Family Interaction and Psychopathology*, New York: Plenum, 1987.

33. For example: R.A.Wells and A.E.Dezen, 'The results of family therapy revisited: The nonbehavioral methods', *Family Process* 17: 251-274, 1978; H.-P. Heekerens, 'Systemische Familientherapie auf dem Pruefstand', *Z. Klinische Psychologie* 17: 93-105, 1988.

34. For example: R.Cohen, 'Verhaltenstherapie zu Beginn der achtziger Jahre', *Psychologische Rundschau* 35: 1-9, 1984.

35. In a series of publications dating back to 1952, Eysenck (e.g. *The Effects of Psychotherapy*, New York: Science House, 1969) has thoroughly perturbed the field of psychotherapy research by delivering empirical evidence that some 65% of "waiting-list" patients receiving no treatment spontaneously recovered after some time. A therapy method needs to beat the rate of spontaneous remission in order to be taken seriously.

36. M.Y.Talmon, *Single session therapy: Dropouts or miracles?*, San Francisco, in preparation.