Dialogs in Conversation\textsuperscript{1} -
the Social Construction of Reflexive Processes within Therapy and Consultation

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The French say, *l'appétit vient en mangeant*\textsuperscript{2} and this expressed experience remains true when it is parodied by saying; *l'idée vient en parlant*\textsuperscript{3}.

Heinrich von Kleist

...if I want to know what I think, I have to talk...

Harry Goolishian

1. My "Little Story"\textsuperscript{4} of the Reflecting Team

My contact with family therapy began at the beginning of the seventies. It was the time when strategic, structural and problem solving oriented

\textsuperscript{1} German title: 
Dialoge im Gespräch - die soziale Konstruktion reflexiver Prozesse innerhalb von Therapie und Beratung.
\textsuperscript{2} Your appetite comes while you're eating (italics mine kd))
\textsuperscript{3} Ideas come while your talking (italics mine kd))
\textsuperscript{4} The French differentiate between stories in which dates and facts are told and little stories ("la petite histoire") about relationships, intrigues, secret financial partnerships, love affairs, diseases, etc.)
methods of family therapy and short-term therapy (Kurzzeittherapie) seemed to represent the peak of development in psychotherapeutic discourse. At that time Haley, Minuchin, Watzlawick etc. were for me the most important. The works of Bateson, who questioned the power metaphor and consequently also the therapist's role as the agent of power, led me to doubt the leading therapeutic models (Deissler, 1986).

It was at the end of the seventies that I found the Milan Team, I read Bateson's works carefully and met him personally six months before he died (December 1979). The Milan Team, who wanted to put Bateson's ideas into practice, became the most prominent and successful model of family therapy (compare the interview with Mara Selvini Palazzoli (Deissler, 1985); Selvini et al. 1977, 1981, 1983.) My colleague at that time - Peter W. Gester - and I were enthusiastic about Bateson's ideas and the adaptations out of Milan. In 1980 in the wake of the success of this direction of thought and practice, we founded the Institute for Family therapy in Marburg. The most important model for us then was the "Milan Model of systemic family therapy". Our colleagues in the international psychotherapy scene confirmed our opinion. We made our first contacts with members of the Milan Team (in 1978) and tried to adapt their model to conditions in Germany and apply it in our
therapeutic practice. We made an effort to practice especially that which the former members of the Milan Team, Gianfranco Cecchin and Luigi Boscolo, taught us as their model: Intervention which were capable of shooting systems out of the claws of their pathological webs with a more or less precise "kick"-Intervention usually started off with a "positive connotation" introduced by the words "we are very impressed...."

What we developed simultaneously, which almost went unnoticed, was a discomfort with this kind of intervention which we "applied" to our clients: Families often reported back to us that what we presented from the expert perspective, a message from the team of experts, was often interesting, but had little to do with what was going on in the family. Aside from the clear reports of improvements and successes many families also complained about colleagues who sat behind one-way mirrors, who they weren't allowed to meet. Others complained about our attempts at manipulation. Colleagues told us indirectly that clients had "complained" about our methods. Naturally these reports left their impression on us and we started wondering if we should could change our methods and how we would go about it. An idea which we considered with ironic self-criticism was as follows: we don't want to serve the clients strategically prepared positive
commentary tied to intervention as a means of interrupting the pathological family pattern. We thought more seriously about whether we should show that we were impressed by the image we ourselves made up of our clients. We speculated that this procedure had the advantage that we would admit our suspicions and that the family could still manage to reap some "benefit" from it - finally we entered the area called "radical constructivism", which was beginning to get popular.

A central statement of "radical constructivism" could be summarized as follows: The statement of a speaker tells more about himself than about that which he wants to describe. The corresponding therapeutic statement is consequently: "we are very impressed with the image we ourselves made up of our clients". Aside from this thought not much of the so-called radical constructivist therapeutic methods remained for us. At least we never applied them to (therapeutic) practice in the described form - unless it was done playfully as a teaching exercise with groups of our students.

As we have already indicated, an important part of our discomfort had to do with the secret consulting behind the one-way mirror. Many therapists were proud of the fact that they were able to impress clients and intervene therapeutically by going behind the one-way mirror to consult with colleagues who
weren't actually there. Then claimed to the client, "My colleagues behind the one-way mirror said:....". This was a way of giving their opinion more weight and justifying every kind of therapeutic operation/intervention: "dividing the team", "confusion maneuver", "paradox intervention" etc. could be created at will and applied according to the therapists diagnostic insight. The resulting therapeutic stories could be sold as forms of strategic interventions in the market of advanced psychotherapeutic training. (?) At that time there were two prominent therapeutic concepts which were supposed to describe the attitude of therapists. These were: "neutrality" (Selvini Palazzoli et. al., 1981; Cecchin 1988) and "therapeutic maneuverability" (Fisch et al. 1982). While neutrality was associated with systemic family therapy, maneuverability was discussed more in the context of problem-solving oriented schools of family and short-term therapy. Especially the latter attitude made the described types of intervention possible. In any case - the authenticity of therapists and transparency of therapeutic procedures played hardly any role in the discussion on therapeutic attitudes, in fact most disapproved of them: the better strategically prepared and secretively disguised an intervention was the more confidence was placed in its effectiveness.
To return to our story: we were increasingly convinced that this secret counselling behind the one-way mirror continued precisely that which was being practiced in classical psychiatric and psychotherapeutic procedures: ...demeaning diagnostic teams of specialists who meet behind the clients back to decide on strategic intervention... (Deissler, 1996).

This brought us to think about what would happen if we held our team reflection in the presence of the client, how the client would react and how these reactions would effect us. At that time we didn't have enough courage to put our ideas into practice - which was also due to the fact that our own reflections behind the one-way mirror ran strategically enough to frighten anyone who might have heard them. Our greatest fear was that our clients would hear what we said and the way we talked about them.

During this time the people from the Milan Team, who remain my personal and professional friends to this day, told us that Tom Andersen in the North of Norway was practicing exactly that which we only dared to think about. As I read his article "The Reflecting Team" (Andersen, 1987), I thought: "Damn, he is practicing our ideas, exactly that which we haven't dared to do!". From this point on, - encouraged by Andersen's article - I began including
"open reflection procedures" in my therapeutic work. The fact that this was done with Peter W. Gester only at the beginning which due to his private and professional reasons for leaving Marburg and his professional activities were transferred to another place.

One method of transition which is rarely practiced today, was that the team reflection which followed a conversation with the client in front of a one-way mirror, was also held in front of the one way mirror. At that time the client system to be counseled moved behind the mirror where the team was sitting. From there the clients listened to the reflecting team and observed the behavior of the therapists. Afterward the rooms were exchanged again.

Today the forms of reflection in reciprocal presence are so varied, that almost every question allows the clients and therapeutic team to negotiate a new form (see below).

I allowed myself to be inspired by Tom Andersen's work again, have visited him frequently since 1987 and finally further developed my work to that which I call "reflexive systemic therapy". Today it occurs only seldom that my counseling procedures aren't planned to include reflecting processes - whether it is with the help of team reflection in the presence of the clients or the occasional self reflection, where I
express - even obviously contradictory - thoughts in the presence of the clients. What else changed in the course of the transition from classic systemic procedures to reflexive methods? What I can say for myself is the following: since I have been practicing the reflexive form of therapy my language related to clients has changed dramatically - it is more constructive, more respectful, authentic and coherent - although sometimes contradictory, and clients also find it more than just constructive and helpful. Today when clients are asked in a collaboratively which method they favor - the classic-systemic or the reflexive - the majority clearly express a preference for the reflexive method. It can be said that overcoming systemic intervention went hand in hand with overcoming the use of conspiratorial language of the cold war with the clients ("maneuver", "intervention", "tactic", "briefing" (negotiations of strategic military maneuvers etc.)

2. Poietological Background: "Language in Conversation"

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5 I use the term, poietological in place of the term epistemological. The central epistemological question is: "How do we recognize that which we recognize?". The central poietological (Constructionist) question is: "How do we construct that which we construct?" (compare Deissler, 1997). Naturally the questions are related.)
It can be said that, the "reflecting team" was created out of discomfort of the therapists', who had problems appearing dishonest, conspiratorial and maintaining an atmosphere of cold war toward their clients when they delivered - with ulterior motives - their strategically prepared messages to the client system. This is a motive which Tom Andersen also mentions in the context of the changes to his practice. Beyond this discomfort, the most important changes accompanying the introduction to reflexive processes are related to the use of language.

As a point of comparison, let us take an example from the end of a session of classical intervention. We read/hear: "The team behind the one-way mirror is impressed by your loving affection for each other...". This introductory sequence with a positive connotation was generally followed by a strategically prepared systemic diagnosis: "...some members of the team wondered about which purpose the conflict between the parents could serve and came to the following conclusion: the parents are inspired by the idea that their children, especially their oldest daughter, should remain at home for an undetermined period of time until she turns her attention to her friends at some point in the future." This sequence - also referred to as a reinterpretation - would usually be finished off with an intervention (in a stricter
sense = prescription): "We recommend that the parents purposely start a fight, at least on two days of the week to give their oldest daughter cause to worry about her parents and to stay away from her friends on these days. The other siblings should secretly observe their parent's fight when they believe that their parents are fighting on purpose and their sister is especially concerned about the parents. - We will meet again at the regular appointment."

It makes a difference if the therapist delivers this kind of message to the clients from the perspective of an expert at the request of the therapeutic team in the presence of the client or if the therapist makes an effort or struggles to develop a fitting and useful understanding of the client's situation. It is completely different if each and every member of the team speaking in the presence of his client has to work in order to come up with constructive ideas and establish or maintain a good relationship to the client. It may be possible to maintain the relationship, comprehensively and creatively follow what the patient said and develop an additional point of view. This will possibly open new perspectives and opportunities for the clients. If we take the example above to explain reflexive therapeutic methods, the reflection by a member of the team in the client's presence could begin: "As I heard the story of the
family the thought came to me, do the negative aspects, expressed in the parent's fight also have some positive element? Couldn't it be that the parents are trying to let their children know that they need them? Couldn't it be that the oldest daughter feels that it is her duty to take care of her parents?"

An other member of the team could add another thought to this perspective and say: "I had an other thought: I wanted to know if ...". The intention of these kinds of less imposing comments isn't to intervene strategically, but to offer the client additional perspectives and in collaboration develop a comprehensive and creative understanding for the future. In contrast to the classical form of team reflection (taking place behind the client's back and followed by intervention), the client can express her opinion on the team member's reflection, and can develop additional perspectives in the course of the conversation.

Still it is important to emphasize that the Milan model naturally can't be maintained as it was in 1979 when I was introduced to it in practice. The Milan Team has gone through many transformations in theory and practice (Boscolo & Cecchin, 1984; Boscolo et al. 1988; Boscolo & Bertrando 1992, 1996; Cecchin et al. 1992 and 1993, as well as Cecchin, 1998). I know

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6 I am referring to Luigi Boscolo and Gianfranco Cecchin, who I know primarily through their (live) consultation practice and from videos. I have known Mara Selvini Palazzoli and Giuliana Prata since 1979 only through literature.)
from educational contexts that they occasionally use variations on reflecting teams in practice. This is also true for other colleagues: I can recall a conference in Konstanz (1989) organized by our educational team where Harry Goolishian, Harlene Anderson, Eve Lipchik and Karl Tomm participated as guest lecturers. At this conference Karl Tomm, who at that time was known as being intimately familiar with the Milan practice as well as being an exponent of interventionist thought and/or interventionist methods (Tomm, 1987; Cecchin et al., 1992), carried on a therapeutic conversation, and was - in one way or another - supported by a reflecting team. If a reflecting and intervening therapeutic attitude contradict each other, if these sessions could be carried out according to the rules of the art and which political effects this conversation actually had, are points which I would rather not go into here. This example led to the conclusion that there are no practices which are completely free of ambiguity and which restrict themselves to a single culture or tradition of systemic practice. Conforming to this development, reflexive therapists are working primarily on "language in conversation" today. This is

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7 Roswitha Schug, Thomas Keller and me.
8 This phrase was adopted from the words of Hans-Georg Gadamer concerning the "hermeneutic transformation in the 20th century": "I wouldn't find the hermeneutic transformation complete until the point where we begin with the insight that language exists only in conversation" (Gadamer, 1996, S. 9)).
because all psychotherapists, but especially systemic therapists, make speaking with clients, the emphasis of their work, and have to borrow from other disciplines, frequently from the philosophy of language (compare Dascal et al. 1996).

I like to call the concept of language (or the attitude towards language?) which I am defending here "social poetics" (compare Shotter, 1993, 1995, 1997 Deissler & Zitterbarth, 1996; Deissler 1997). What is meant by that? Bateson has often emphasized in his publications, that for him relationship has priority over everything else. In Cologne in 1979 he said in a workshop, "Relationship precedes". What are relationships between people like or how can a person relate to others? Simplified, there are two ways to go about it: by talking or by doing something together. Conversations, dialogs, discussions, negotiations, etc. as being different from participation in joint action, cooperation, collaboration etc. whereby this differentiation can implies that speaking and doing are related activities. Each is the complement the other and are inseparably joined together. With the help of language a distinction between speaking and doing can be created and then removed. If the separation created by language is bridged, our language assigns the following general term: it's called communicating
or relating to each other whenever speaking with one and other is united with a common activity. The "Social Constructionism" in general (compare Gergen, 1994) and specifically in the area of psychotherapy (McNameee & Gergen, 1992; Anderson, 1997; Deissler, 1997) carried these ideas further. Gergen summarized it similarly to Bateson: "Communicamus ergo sum" (Gergen, ibid.). Within Social Constructionism the act of speaking with each other is given a special place along side the construction of reality. The concept of social poetics takes its special status into consideration: It can be seen as an attempt to make use of the premises accepted by Social Constructionism for conversation - especially in a therapeutic context. These premises include the following:
1. All knowledge and every kind of social construction is created through communication, especially in conversations.
2. The "bio/psycho/cognitive apparatus" of the participants in the communication processes can be considered a prerequisite for carrying out the processes of communication. Terminology such as "cognitive apparatus" are products of linguistic (social) constructions. The prerequisites for communication mentioned previously do not fulfill all the conditions for

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9 "We communicate, therefore I am"
communication: not until at least two people communicate with each other and a third person describes it are these three creating their conversational reality together.

3. We don't perceive our social reality primarily through our sensory apparatus, such as the optic lens, but through that which unites and separates us: talking and listening to each other as well as doing things together. In conversation we develop ideas, stories and understandings, which we share and which also differentiate us.

4. Concepts don't enter their so-called arena of social existence until they are created as concepts in conversations, are used, reflected etc. Concepts do not exist independently of their usage in communication, especially in conversations. Their meanings (in context) and the usage (frequency) are constantly being reformulated and redefined in conversations. They receive their significance through practices bound in space and time which are in turn embedded in "forms of life" (compare Wittgenstein, 1984)

What makes up the social poetics of therapeutic conversations? A few considerations are needed before this question can be answered:

10 There are more Social Constructionist premises which could be included. However the formulation and discussion is beyond the subject matter of this paper.)
(1.) If the Greek etymology of the word poetics (poiein) is taken seriously, the word means "to make, to manufacture...". Considering the current discussion of ideas on therapy, the Greek word "poiein" could be seen as equivalent to the word "to construct". Also according to the Social Constructionist definition of constructing, it always occurs in conversations, therefore social poetics identifies precisely this process of linguistic construction.

(2.) We are used to constructing our world in conversations, in which we make use of divisions, differentiations, or even contrasts to emphasize what we want to describe and embed these differentiations in a narrative context. In this way we distinguish

"talking together is something different than\textsuperscript{11} collaborating (acting together)": talking / acting
"dreaming is something other than confronting reality": dream / reality or
"the map is not the territory": map ≠ territory\textsuperscript{12}.

In this sense it can be argued that psychotherapeutic conversations are talking about the contexts of action taking place outside the therapy room. Just as one can be convinced that it is about imagining

\textsuperscript{11} makes a difference)
\textsuperscript{12} An appropriate phrase from Bachtin (see below) would be: "the narrative (product) is not identical to the narrative process": narrative ≠ narration and "that which is presented is not the same as the presenting process": the presented ≠ presenting process.
(dreaming) the reality which exists somewhere else. Or psychotherapy could be thought of as an outline (map) of a specific future reality (country). These differentiations can be sensible and useful. We encounter them both in therapeutic as well as in every day conversations, although in an unspoken form.

Once the above mentioned considerations are accepted, the differentiations are not given by nature, but are of a linguistic nature or are created in conversations. That means, they don't exist independently of the conversational contexts where they are constructed and their meanings are negotiated.

(a) These considerations can be taken further and one can say that these linguistic differentiations don't (necessarily) describe mutually exclusive differences. That means that they aren't either/or relationships (such as it is either dream or reality). This means that these differentiations can be either more/less one/as well as the other either/or & neither/nor relationships. For example a "dream could also be seen as a blueprint for reality" which has already begun (for example an unfinished house).
(b) In addition the principle of poetically dissolving limitations between the differences created can take effect\textsuperscript{13}. Tom Andersen has pointed out repeatedly that both the questions which the therapist can ask as well as the commentary expressed in the presence of the client should be "appropriately unusual" (see 1990). By that is meant that questions as well as commentary should be extendible(?) as well as go beyond that which the clients said. If you try to minimize the differences made between dream / reality, map / territory, and conversation / cooperative action, take the divisions between the differing pairs and postulate: A therapeutic process becomes more poetic as it approaches these divisions, obscures them and finally removes them. Once the divisions are no longer clear, they will be questioned. They will be more or less obscured or completely removed: the oppositional nature of the pairs of concepts mentioned will be suspended: dream is reality, the map is the country and speaking to each other is working together.

(c) It has already been made clear that we create differences in conversations which can serve to clarify, contrast and explain the content of conversations (material). One of these differences

\textsuperscript{13} I would like to thank Sheila McNamee for the stimulating discussion in this context).
which is constantly being linguistically created, although it is seldom reflected, is the contrast between the process and the intent of a therapeutic conversation. It can be said that the "process" of therapy is talking with each other, while the "intent" lies in "the solution to the stated problem". For this reason the conversation (the process) is applied to achieve the intent. What happens when we combine the process and the intent, or remove the division between them? Therapeutic conversations become their own intent: The intent is the process and the process is the intent. This is the consequence of Goolishian's claim. He said, the intent of a therapeutic conversation is to maintain the conversation (compare Deissler, 1997, S.94 ff).

(3) These poetic moments in therapeutic conversations are created primarily by mutual comprehensive understanding which is enhanced through an initial creative understanding (compare Shotter, 1997, Deissler, 1997). The latter is followed in turn by a specific creative moment of reality

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14 I would like to call your attention to a discussion in which the question was asked, what the "intent" of a therapy should be. As an example I could imagine a radical short-term therapist whose intent for a session is that at the end of the session the client no longer knows why he came to therapy: it could be argued that the therapy was successful in just one session: the client has forgotten his problem and it therefore no longer exists for him. Boszormenyi-Nagy has expressed an other extreme of the therapeutic intent: according to him one of the following generations of the family should live free of symptoms (compare Deissler, 1985).
construction which finally opens opportunities for new areas of action. What is meant by the previous paragraph is: the differentiations made will be comprehended by each of the partners in conversation and confirmed in their meaning or be understood. An example for this would be the therapeutic question "have I correctly understood that you prefer the parents you wished for (dream) to the parents you have (reality)"?

Creative understanding removes the divisions between the two (or identifies another). This could occur when a therapist asks "Assuming you had the parents you wished for then, what would be different today?" A client could answer: "Then I would feel both free and loved."

The specific creative moment which could follow and would lead to new possibilities, would be part of a conversation about the possibilities of a present and future which would include "feeling free and loved": "What would you do differently today if you felt free and loved?"

Three prerequisites of social poetics should be met by therapeutic conversations:

(1) A therapeutic conversation describes a dialogical (linguistic) construction process.
(2) This linguistic construction process realizes itself primarily with the help of differentiations created in conversations.
(a) These differentiations can contradict each other, can be related to, can complement each other as well as be partially or completely identical.
(b) The boundaries between these differences created in language can be poetically dissolved.
(c) The aim of a therapeutic session is, in the sense of removing the boundary between the process and its intent, to maintain the conversation.
(3) The linguistic construction process of a therapeutic conversation assumes that there is mutual understanding, which can be divided into a comprehensive and a creative component which finally culminate in a specific creative therefore poetic moment, which can be surprising and novel (unpredictable).

At this point the question of how these prerequisites can be applied to the process of therapeutic conversations arises. First, I would like to describe a case example which clarifies these elements:
This is the story of a single mother with three children who lives in a town on the edge of the Wester Forest. Her husband died of cancer about ten years earlier. Shortly before the death of her husband she came for therapy and had a few
sessions after he died. About eight years later she came with her then sixteen year old son, who had social problems in school. The consultation on this problem took three sessions. Again after about two years she came because her mother had died - at this point I will begin the story of the last consultation:

Mrs. Taubert\textsuperscript{15} said that she has felt a rage against men for some time. She took advantage of every opportunity to track down macho behavior in men and expose it using feminine aggression; and whenever possible, denounce the man in front of an audience. She obviously enjoyed doing this, but it also made her worry. It was fun to unmask men's affectations of potency with sarcastic commentary, but she was worried about where this behavior was coming from. This became clear when she talked about her fantasy of her mother's upcoming funeral: she said, she would most like to use this opportunity to tell all the funeral guests that she was sexually abused by her father and brother, who is a police officer today, and that her mother covered up for her father as well as her brother. She described the scene at the funeral in tears and with anger and finally imagined standing in front of all the mourners and showing them her raised middle finger. In the

\textsuperscript{15} The client's name has been changed. She read the written description of her problem and authorized it for publication.)
therapeutic conversation and the intermittent reflecting phases it was carefully examined if and how the client's aggressive behavior toward men could be related to the long unspoken abusive behavior of the father and brother. Thereby the present anger was much more important than the mourning and helplessness.

An additional short episode from a session also dealt with this topic: Mrs. Taubert told that she was often visited by her neighbor with whom she had an ambivalent relationship. Where things such as gifts were exchanged. The neighbor took the liberty of constantly watching her through the window of her house across the street, and criticizing the fact that she lived alone. As this neighbor recently visited her in the company of another neighbor and they both came to mention the missing male element in the house, terrible emotions rose within her which she described as "rejection and anger".

At first, this story didn't make any sense to me in light of the problem stated. Mrs. Taubert said that the neighbor was often beaten by her drunken husband and that she covered her bruises. Everyone in the neighborhood knew about it, but nobody talk about it - especially not in the neighbor's presence.

In the reflecting phase, which I carried out with a colleague, we came up with the question if there could be a relation between the neighbor's silence
and the client's silence - both conceal abusive male behavior. An other questions arose, if both women weren't demonstrating protective behavior toward men and if Mrs. Taubert especially rejected the behavior in her neighbor which she couldn't tolerate in herself.

These relations were - as stated - created reflexively by the therapist and his colleague in the presence of the client. They have neither a claim to correctness nor to objectivity and represent nothing more than an additional perspective on the client's story. - The client was silent for a while after the reflection and carefully agreed to this perspective: "There could be a relation." She felt understood and saw new possibilities for action - partially toward her neighbor and partially for the explosive topic of the funeral, the angry and concerned fantasy about the funeral lost its significance. The division between her "problem" and that which she saw as the solution had been partially dissolved (compare Anderson, 1997; Deissler, 1997) - it was irrelevant and was no longer the topic of discussion.

3. Psychotherapy Research: Conversation in Conversation

In order to judge a therapeutic procedure by its effects, one would probably compare the
effectiveness of this procedure with that of others. This is generally done with the help of "before/after" examinations\textsuperscript{16} by which the effect of the procedures being compared are measured against the appearance of specific symptoms. If a new procedure achieves the same or exceeds the effectiveness of an older proven procedure, it will usually be added to the catalog of effective procedures. It is important to remember that the differences between the effectiveness of the procedures being studied are measured and compared primarily quantitatively. Qualitative differences will also be discussed but will not receive as high a rating.

The problems in the scientific procedure become clear when the following procedures are compared: individual therapy and family therapy classical systemic (family) therapy and reflexive (systemic) therapy (team reflection in front of or behind the one way mirror) family therapy and therapy forms oriented toward "linguistic systems" (Anderson & Goolishian, 1990)

The difficulty lies in treating these approaches equally in a certain sense, neither rating nor obscuring their differences.

\textsuperscript{16} The researcher's attention is directed largely to the "quantitative measurable reductions in the severity of symptoms" which can be recorded with the help of (standardized) tests.)
In light of this challenge, an alternative or additional option is to carry out qualitative comparative studies. With the help of these types of studies the qualitative characteristics of various therapeutic procedures can be studied and examined in finer detail. I undertook such a study in 1978/88 (Deissler, 1997). Several consequences can be indirectly drawn from this study, which effect the practice of consultation and especially the practice of psychotherapy.

In the following sequence;
(1) (conventional) individual therapy
(2) (classical) systemic collective(?) therapy
(3) reflexive collective therapy

each of these procedures demonstrates a higher degree of complexity. This has the effect as structuring the conversation processes becomes more demanding. The following points can be seen as advantages: the density of information, transparency and acceptance of or by the client are higher. That means the closer the approach comes to reflexive therapy, the more the client and therapist create information: this is true for the procedure (transparency) as well as for the multitude of ideas related to the stated problem (information density). In the same measure is also becomes clear how the

17 To save space I would like to refer the reader to the literature cited above. The numerous details on the methodology and content of the study allows it to be discussed here based on the conclusions drawn from it.)
therapists ideas come to be: therapists develop their ideas in the presence of their clients. The clients can immediately judge them - they can be accepted, modified or rejected. This also gives the therapists immediate feedback on the quality of their work, because the clients have an opportunity to comment on the therapist's ideas. This increases the chances that the clients will accept the process and the contents reflected; it also helps the therapists adjust to the clients. This eases the process of getting used to each other. Finally it can also be said that actively involving the client in the process of consultation improves the collaboration between both - the clients and therapists.

If these advantages of the reflexive procedure are conceded, one must ask why haven't they been taken up and put into practice? My experience in dealing with different consultative contexts has shown that a distrust of transparency is more often on the side of the professionals than on the client's. Personally, I am convinced that it is also due to the difficulty educated professionals have admitting "a lack of professionalism" (Anderson & Goolishian, 1992) in the sense that they as the therapist or counselor in many respects learn more from the client than the other way around. As long as the professional or personal contracts of psycho-social experts include conditions which damn them to be in
possession of better knowledge than their clients, they can't allow themselves to adopt an attitude of learning, neither in the presence of the client nor with their colleagues, not to mention admitting to helplessness in certain situations.

This problem also effects the way research is done. As long as psychotherapeutic researchers fancy themselves as coming from outside and in possession of the single "correct or better method", they will continue to study psychotherapeutic conversations in the sense of "first cybernetic" methods. That means, they exclude themselves from the psychotherapeutic context as observers and organizers which makes the "material" of their study the "object". This is a primary cause of the distrust and rejection they encounter from psychotherapists and their clients. It has been demonstrated that other approaches to research are possible by a.o. Sheila McNamee (1993), Walter Zitterbarth and me (1996) as well as Tom Andersen (1997). These approaches can be summarized according to Sheila McNamee as: "psychotherapy research as conversation" - in other words: 'scientific conversations' enter into a conversation with 'therapeutic conversations' and make the common conversation the subject of the study.
4. On the Construction of Consultative Contexts of Reflection

During the course of time reflexive procedure has asserted itself in my professional practice more and more. That means that there are hardly any professional contexts in which contents, intentions, etc. aren't discussed in the presence of the mandate. Mandates can be clients in the conventional sense, or colleagues who desire supervision or non-psycho-social mandates. I would like to describe the three categories of these differing contexts as follows:

a. Therapeutic Context\(^\text{18}\)

Therapy in which my participation is primarily as the responsible therapist take place in Marburg in my private practice. They make up approx. one third to one half of my work week. They are financed by health insurance in a so-called "delegation" (e.g. a MD "delegates the therapy to a psychologist"), which means the mandates of the therapy are both a doctor and the clients. The therapies are carried out as "short-term therapies" according to an agreement with the health insurance agency, which also excludes the possibility of applying for extensions. The clients are informed of these conditions.

\(^{18}\) The methods described here represent the "usual case". The methods are frequently modified when clients want to talk about the form of the procedure).
written in the clients' presence who also agree to the information presented, and - as diagnosis is demanded by the insurance companies for paying the therapy - the very diagnosis is negotiated between clients and therapists. Only applications which the clients have read and agreed to are sent to the mandating doctor and health insurance officials.

The sessions are structured so that the clients are informed of the usual procedures and are asked to consent to the participation of colleagues and/or students. The clients are informed that the colleagues present will take part on intermittent reflection on their conversations and that they will have the opportunity to express their opinions about the ideas developed. Only if the clients have given their consent to this procedure are we joined by the colleagues for the reflecting process, who enter the room at this point and introduce themselves before the conversation begins. If the clients reject the proposed procedure, possible alternatives are discussed\(^\text{19}\).

Individual conversations without the presence of colleagues are an exception, for example many clients don't want to talk about "incest" or other delicate topics in front of others. Many clients reject

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\(^{19}\) The option of a long-term therapy with other colleagues is no taboo. Many clients select this option if they are interested in a long-term therapy.)
reflecting colleagues who they know from contexts outside the therapy. Others prefer a first conversation with just the therapist in order to "establish trust". In about 95% of the cases (estimated percent) the clients agree to the procedure with "reflecting colleagues". Most of the client's reactions to the reflecting phases are positive to enthusiastic. Usually they don't want to do without this method and express regret when no colleagues are present.

The personnel constellations of the client systems vary considerably. They vary according to the questions which the clients bring into the therapy and the constellation of the people making up the "problem system". The client systems could include individuals who are interested in an individual therapy, patients of psychiatric hospitals accompanied by medical personnel, heterosexual or homosexual couples, parents with children or sometimes with a caregiver or teacher, complete families, or doctors who come to therapy with their patients.

A session usually lasts 1 1/2 hours. The length can vary according to the topic and individual wishes.
Usually in addition to the therapist a colleague as well as a student are present. At present three colleagues work on different days of the week\textsuperscript{20}.

b. Supervision Contexts
There has been a lot said and written about the various forms of supervision (compare the first issue of the "Zeitschrift für Systemische Therapie" (1997) or the issue on "Familiendynamik" (1997)). Generally supervision is thought of as a forum for reflection, where the colleagues talk about important topics of their psycho-social work under the direction of an experienced colleague. Traditionally, so-called case supervision is differentiated from team supervision. The fact that neither of these forms occur in their pure form doesn't require an explanation. Here it should be briefly mentioned that for both of these forms, contexts can be constructed which allow for the integration of reflecting phases: One can structure a "problem oriented" conversation and ask two or three colleagues, who are not involved in the case, after some time has passed, to exchange their thoughts on a conversation between the mandate/s and supervisor (reflection phase). After the

\textsuperscript{20} These colleagues are Heide Schäfer, Manuela Krahnke and Walter Zitterbarth, Ph.D. Two of the above mentioned have completed training in "reflexive systemic therapy", one is still in training.) The reflective conversations take place either between colleagues and students and/or with the therapist (kd).
exchange of ideas has been completed the each colleague or all of the colleagues involved can express their impressions of the reflection. Finally, the formal structured ritual will be opened and all the colleagues present can take part in an unstructured exchange.

Naturally this form of supervision isn't the only possible form, there are countless other variations. In addition to those presented here it can be added, that the participating clients can be represented by other members of the team in a role playing exercise. In this way genuine consultative conversations can be simulated. Conventional forms of supervision do not replace that which is only possible in reflecting processes where the client is present: reflexive (live) consultations.

c. Reflective (live) Consultations
As my colleague Roswitha Schug and I have described in an article, there is an alternative to the conventional form of supervision which includes the clients in the process of supervision (Deissler & Schug, 1997). We called this form of collegial

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21 At this point, I permit myself to mention that the client, as the final customer in the classical forms of supervision, is not present - this is even more dubious in light of the fact that supervision is often justified as customer orientation. It remains of interest that in classical forms of supervision the clients have no voice - they are not present.)

22 This procedure developed approx. nine years ago by the so-called Langenfeld Seminar for Collaborative Studies and since then has been tested
consultation reflexive consultation because it makes use of the principle of the reflecting team and allows for a consultation process which is mutual, structured as a dialog and open to many sides. Expressed simply, it is a conversational form whereby a therapeutic team contracts a consultation team to speak with them in the presence of the client or to work on a specific problem. What is important in this procedure is that the clients don't merely listen but express their opinions on the therapeutic team's discussion. They are also asked about their intentions as the mandate of the therapeutic team. The most important question for the consulting team in the most general form is: how can we organize a process of conversation together in which all the people involved in the problem receive the same amount of space and time to present their concerns and exchange ideas in a dialog? - This question goes for the team of clients, of therapists and for the consulting team. As this process is being structured every member of these three sections should receive both space and time to speak as well as to be heard. - As long as an individual doesn't want to speak, this will be respected. - The special task of the consulting team

and successfully applied in countless contexts. The Langenfeld Cooperation Studies developed from a contracted supervision, which I received nearly thirteen years ago from the management of the "State Clinic of Rheinland in Langenfeld".)
during this procedure is characterized by the reflection phase, in which part of the team exchanges thoughts about the conversational process. Finally the client and the therapeutic team as mandate are given another chance to speak. What is particular to this procedure is that it enables in one and the same place, at one and the same time a sequence of individual dialogs which can be simultaneously interpreted as therapeutic, supervisory and reflexive (in the sense of a reflecting team). As has been justifiably criticized, these conversations require a lot of organization: in order to collect those willing to collaborate several invitation conversations as well as time and patience in carrying out the consultation are necessary. This takes at least an hour with a small number of participants. The larger the number of participants, the more effort is required to prepare and lead the conversation. This effort, however, pays off, and can be summarized as follows: the more time the participants take in carrying out such a conversation, the more time is saved in the following individual conversations, because everyone hears what the others said. An additional advantage is in the opportunity to "dissolve the most difficult psychiatric problems" (Deissler & Keller, 1996; Deissler, 1997) to the point of solving conflicts in the area of
5. "Completely Normal"?: Dialogs in Conversation

Ten years ago I talked to one of the participants of a continuing education course about "something special" that one could make of his life and how to go about structuring it to bring about that which is referred to as "quality of life". She surprised me by defending the standpoint that one should try to "perfect the ordinary". What does "perfecting ordinariness" have to do with psychotherapy, reflecting processes and social poetics?

I would like to mention a few of my convictions (presumptions) which have formed during the course of my psychotherapeutic practice and have held on relatively persistently. Afterwards I will return to the question I just posed.: First I would like to assert that poetic moments - as they were described above - occur every normal conversation. Furthermore I would like to claim that if this weren't the case - no satisfactory communication would exist, whether in romantic relationships, in problems at school or in questions of politics and economics. That the business of psychotherapy is expanding in spite of this, is, in my opinion, due to the fact that many people don't call themselves to account for
everything they do "well" and for their "successes". In this day and age it seems as though clients go to psychotherapists to get to know their positive sides. If one were to follow my considerations and want to research the poetic moments in conversations, the first step should be to look at everyday conversations, which were described by their participants as successful, satisfying or at least stimulating. Everyday conversations offer such a variety and abundance of opportunities to learn about social poetics and the construction of opportunities, that psychotherapy can be seen only as one of the smallest categories among an endless number of other forms of conversation in life. I would like to present the thesis that conversations such as those with friends, family members, taxi drivers, shamans and prostitutes can be more successful (in the sense of psychotherapeutic intent) than psychotherapeutic conversations. If this assumption is true, how can psychotherapists rationalize practicing their profession? Should they give up their professions? - If such conclusions are drawn from

23 Compare especially the "positive connotation à la Milanaise" or the "compliments à la shortterm therapy" or the "orienting towards recourses", which gave rise to the growth oriented family therapy.)

24 This idea doesn't seem to be so terribly irrelevant: On Monday the 27th of October 1997 the following article appeared in the Süddeutsche Zeitung (P. 12): "Therapy in the Bistro. Parisian psychotherapists offer counselling in bars".)
what has been said, then the statements weren't clear enough: If the profession, psychotherapist, is justified, then because therapist with their training, and based on the form of collaboration with their clients, should be in a position to increase the probability that poetic moments will be created. In therapeutic conversations that which also occurs in every day conversations should, through the special structuring of the conversational form and the flow of conversation, occur more often also the special quality of poetic moments should be supported. This happens, according to the theses of this paper, especially then when dialogs enter into conversations with each other.

In the sense of the thesis developed here, an ideal of a successful psychotherapeutic conversation is one after which each of those involved agree that the conversation benefited them. It should have more in common with a normal every day conversation than with therapeutic rituals with all its professional and status oriented trappings as well as mysterious mumbo-jumbo - especially therapeutic, psycho-social or even psychopathological jargon. Every day and therapeutic conversations would consequently differ very little - aside from the external circumstances (contract, context, etc.). To paraphrase Gadamer the therapist shouldn't speak the language of the client, nor should the client speak the language of the
therapist. Rather a new, common language should develop which is characterized by mutual comprehension and creative understanding.

I would like to bring this thesis to a close with one additional thought in this direction. This thought was inspired by Michail M. Bachtin, a Russian literature theorist who is only now starting to become known among psychotherapists in the German language area (compare Seikkula, 1993, 1995, and 1996). Bachtin (1989) differentiated written narrative forms which come to an end (such as epic poems) from those which are open to further development (such as novels). Analog to this differentiation, some forms of conversation can be "finished" when they aren't open for conversational development with their unexpected turns. In my opinion, forms of psychotherapeutic conversation are only true to their unattainable, intangible form when they are open for the unresolved present. Bachtin mentions qualities in the discussion of the unresolved present. I would like to list a few of them here because they seem to be valid for every day conversation open to the present and as such are also relevant to therapeutic conversations oriented to the present: "unresolved, problematic, undecided, constantly reevaluating, reinterpreting, temporary, versatile(?),

25 One can also talk of «sujet», «problem» or «topic» etc. Bakhtin calls it in the context of his analyses of forms of narratives «chronotopos».
lively, open; becoming (or being created?), flowing, without a beginning, unending, without any real substance, silly and serious, relating to the present, defeating fear, making research possible, unknowing, predicting, linguistic, ideological, initiating, creative, familiarizing, turning into a carnival..."

If we accept these for current therapeutic conversation, that means that we, analog to Bachtin's "bringing the object of artistic representation down to the level of unfinished and flowing contemporary reality" (Bachtin, ibid. p. 250), have to bring the topics and forms of therapeutic conversation down from the high pedestal of its foundation in conventional scientific aspirations. We are entering the sphere of abstract, immaterial, bottomless conversation which finds its creative power in social poetics. Possibly we will perfect the ordinariness of every day conversations.

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