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Is second order practice possible?

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This paper looks at the difficulties in applying second order ideas to therapeutic practice. It considers, first, what second order ideas are and how they relate to one another, second, what second order practice looks like, and third, the problems these ideas create when trying to apply them. It is argued that their pure application is impossible given our strong moral beliefs, but that there are good ethical and aesthetic reasons for taking such ideas as far as we can.

'There are always people who possess a theory they cannot act on.'

(Leih Tzu from The Book of Leih Tzu)

What's the problem?

Many of us are now familiar with second-order ideas. They may be poles apart from the theories we commonly use in relating to the world (and this could be part of their attraction), but they make logical sense, they seem to fit and explain our experiences, they appear to be an ethical advance over first order ideas, and their interlocking qualities give them an uncommonly elegant appearance. So why do most family therapy teams continue to operate almost entirely behind the screen, and why do team discussions generally reflect beliefs that not only should clients change in specific ways, but that we can help — or even make — them do this?

At one time we could have said that practice just takes time to catch up, but it's ten years since Lynn Hoffman wrote 'The case against power and control — towards a second-order family systems therapy'. If these theories are so helpful and relevant, why don't we use them more? Maybe the problem lies with the theories rather than the practice?

Whatever the reasons for this lack of application of the ideas, the current gap between theory and practice makes a nonsense of professional credibility, allows us to deceive ourselves that we have taken on more ethical practice (if, indeed, second order theories are more ethical) and will puzzle those of us who look for congruence between theory and practice.

Which theories are we talking about?

In the move to borrow terms from other disciplines, 'second order' has accompanied words like 'cybernetic' across from the realms of science and mathematics. It is used to mean taking a step back from something so that you can consider your relationship with it as well as consider the thing itself. One of the elegant aspects of these theories is the way they each link to another of the theories and, thus, each subsequent theory maintains a connection with the first. You could say that, given the first theory, most of the others are logically consequent upon it.

Theories about the way people are structured

Maturana, a Chilean biologist, coined the word 'autopoesis' to describe his idea about how people and other living .systems have an internal structure that determines how they react to things (Maturana and Varela, 1973). This idea of people being structurally determined' means, for example, that I might respond to a threat by running away whereas yon might respond to the same threat by facing it. It cannot then be the threat which determines our response but something that's different in us our internal structure. Of course the threat does connect to the response, but only inasmuch as it 'triggers' the response - it could equally well trigger any response, or even no response at all. It is our internal structure which determines how or whether we respond — i.e. what is triggered — not the stimulation.

If we accept this idea, it becomes logically consequent that you cannot make someone respond in any particular way. Someone threatening me may hope I will run away but they cannot guarantee it. Even if that's what I have always done before I might decide it's now time to stop and fight. There is no way for them to predict with certainty how I will behave. This is Maturana's idea about 'the impossibility of instructive interaction'. You cannot, during an interaction, instruct someone how to behave and know they will do it. Nine times out often, when we invite family members to, for example, 'Come in and sit down', they will do this, so when a family member insists on staying in the corridor or remains standing, it reminds us that, as a general rule, you cannot make anyone do anything. Of course you might increase your chances of exacting compliance by offering rewards or threatening physical violence, but people may still surprise you, and any compliance is more likely to be short term, with resentment following the withdrawal of the rewards or threats.

We are all, then, unpredictable. We may learn or change, but only when we determine to. We comply with requests or orders if we decide to. We can interpret information, but only in ways that the filter of our internal structure allows.

If this begins to sound as if family therapists' preoccupation with interactions is misguided, Maturana's ideas about 'structural coupling' do support our notions of connection, context and fit (Leyland, 1988). Being informationally closed does not mean we are unaffected by other people or our environment, and structural coupling describes how this happens. People, Maturana says, have complex interactions with each other and, while we can only trigger each other to respond in the ways our internal structures allow, each triggering causes our structure to adapt and learn so that a subsequent identical triggering might cause something quite different to happen.

In a relationship — i.e. a structural coupling — the ways in which people trigger each other and what becomes triggered are determined by their different internal structures. As we interact with each other and the environment, our lives become a continuous stream of structural couplings, each one liable to leave its mark on our internal structure. Not only is this inevitable, but our social and physical survival depends on our abilities to couple with others so that we can have relationships, purchase food, organize shelter and so on.

If we only perceive things through the filter of our internal structure, and the effects of our couplings on that structure are unpredictable, then the idea of objectivity — of being able to perceive something without it being filtered, seeing it as it really is — becomes suspect. If you and I both look at a family through sun-glasses (a kind of filter), we might agree that, in general, they look darkened, although different tints will give us different perspectives. If we remove them we might agree that they look brighter, but you might sec a close supportive family where I see enmeshment and dependent symbiotic relationships, or you might see protection where I see interference. Clearly neither view is 'objective' (although your view is likely to be more facilitative).

If we decide not to use the word 'objective' because we realize how the perceptive senses of our structure alters all information, then everything becomes subjective. (Of course, once everything is subjective then this word also becomes meaningless.)

'Reality' (a word we use to fortify our subjective view of the world) thus becomes a subjective description that is agreed upon by enough people to be a useful social shorthand. We cannot know how well our realities reflect 'reality out there' - if indeed there is one - which we also cannot know.

Next, we should examine the notion that we can just observe - with its implications of objectivity - anyone with whom we have a relationship. Any observation comes as a result of a structural coupling which is liable (in unpredictable ways) to change both our structure and the structure of what we are observing. We are, then, watching as participants of the interaction - from inside it - not as observers from outside it. As we have to be structurally coupled to family members to engage therapeutically with them we are likely to be affecting them and affected by them. Even the one-way screen can only offer a different perspective - it cannot prevent this mutual influence.

Another area affected by the theory of structural determinism is that of power or control. If our behaviour is determined by our internal structure, it cannot therefore be reliably predicted or brought about by another- it is beyond another person's ability to control us. Of course, the better we know someone, the more skilled we become at coupling with them in ways that are likely to cause them to decide to co-operate. But being fairly skilled at securing a hug from your partner when you want one is only comparable with securing a handshake from a client. Expecting family members to undertake a task when you ask them may be more akin to expecting your partner to have sex when you ask.

Using threats of physical force as an aid to structural coupling may increase your chances of temporarily getting what you want but, as Cecchin *et al.* (1994) point out, taking a longer term view of events results in a different perspective. Making children behave by, for example, locking them in rooms, beating them or frightening them is likely to have consequences for the parents that are far more damaging than their children's disobedience. Similarly, political attempts to exert large-scale control on an unwilling citizenship - be it to impose communism or the poll tax - seem destined, in the longer term, to be as damaging for the would-be controller as for anyone else. Trying to control outcomes ignores the effects of the 'loop' structure of the larger system over time (Hoffman, 1993). Securing compliance in the longer term relies on a benevolent coupling that allows all parties to feel that they have choices.

The notion that we can 'change' people is thus under threat. The best we can do is probably to negotiate how to help them make the changes they want. We can try to establish a structural coupling where choice prevails over pressure, so they can make changes to their own structures and to how they become triggered to behave - if they wish to. Therapy models that ignore these constraints and encourage the therapist to direct family members run the same long-term risks as do dictators and other bullies.

When therapists state their moral position and seek to secure family members' agreement to it (i.e. the therapist tries to persuade family members of his moral superiority over theirs) we see another example of therapists attempting to influence and control. The therapists' 'superior' position is again evident in ideas of 'empowerment'. This has the same connotations of hierarchy in the therapeutic relationship and implies someone 'higher' giving something to someone 'lower' (Hoffman, 1993).

The idea of the life-cycle is a further target for these theories. If we only change in unpredictable and uncontrollable ways, then the validity of ideas about 'norms' becomes doubtful. While we may see patterns or general tendencies shared by people during their development, we cannot equate this with 'stages people go through' and impose such a rigid structure on people's life stories as if it explained something. Using

theories that explain one person's behaviour as a basis for explaining another's risks a sense of irrelevance on the client's part.

Theories about how these relationships are distinguished and how this distinguishing affects the relationships

As we are structurally determined beings, our subjective realities, i.e. the things we 'know' to be true, are 'constructed' by us. We generate views of the world that become our reality. This is the basic idea behind 'constructivism' and it closely follows Maturana's ideas of informational closure. If we cannot know what is really out there, then 'out there' knowledge or information cannot pass directly into our minds, and our worlds must be constructed by us and our views of other people are also constructed by us. If we construct everything we observe, then we are, to all intents and purposes, observing ourselves. We do not so much observe others as join with others to observe ourselves.

Social constructionism adds another layer to the theory of constructivism and says that what we 'know' is not constructed by us in isolation but in social interaction (Gergen, 1985). It is in conversation with others that we construct our ideas about the world (Hoffman, 1993). As we read newspapers, watch television, listen and talk to others, so our beliefs and knowledge form and re-form. What we once 'knew' was madness we now 'know' is confusion; what we once 'knew' was ugly we now 'know' is art, what we once 'knew' to be hate we now 'know' to be fear. What our ancestors knew to be the moon, we still know to be the moon, but as our relationship with the moon changes so does the meaning of the word 'moon'. We now know it's not made of cheese because human beings have walked on it and, with this, its symbolic and metaphoric meaning and usage changes. All this does not prevent, let's say, a cat always having been and always being a cat - 'cat' has been a reliable construct for us - but such consistency of meaning depends on our social interchanges not altering the meaning. There is no essence of catness', no permanent qualities that we can know about and no fixed or prior meanings hiding in the word 'cat'. Our knowledge of cats changes and renews itself with each interchange we have about them (Hoffman, 1993). Having already abandoned the idea of a concrete objective reality we must accept that our words and language cannot describe such a reality. Rather, they describe an idea or view that we have generated (Leyland, 1987), implying a perspective rather than depicting anything 'real'.

One implication of Maturana's ideas is that 'all problems are in language' (Efran and Lukens, 1985). A problem starts when someone says 'I have a problem' and ends when they say 'I do not have a problem'. Although 'problems' only exist when they become defined as problems, it is naive to assume that no uncomfortable issues exist beforehand - just that it has not been called a 'problem' yet or activated the problem determined system.

When a group of people agree on something being a problem, then it is their sharing of the definition of it as a problem that connects them to the problem and justifies therapists meeting with them to resolve their problem. The problem has determined - through the people who discuss it - who is relevant to it and they are thus the 'problem determined system' (Anderson *et al.,* 1987). While just thinking of it as a problem is enough to bring it into your mind, only calling it a problem to others will give it an existence of its own - at which point it will start to gather up the problem determined system.

It is tempting to assume that the problem determined system is generally the family, but 'family' exists only as a word and no two family members are going to fully agree on what 'family' means. Each family member has a different 'family' and you cannot therefore talk lo a family or elicit family views, myths, roles or anything else. You can only discuss how different family members' concepts of 'family' relate to each other and how this generates difficulties (Efran and Lukens, 1985).

We are essentially dialogical beings and we evolve knowledge, meaning and the meaning of action through talking and other interaction (Anderson and Goolishian, 1988). As these couplings can lead to change in our internal structure, the relevance of 'narrative' theory is clear. These ideas suggest that we construct stories about ourselves and others through social interaction and the therapist's task is to help people construct more useful stories. As our knowledge IS only a story, no buried truths exist to excavate (Hoffman, 1993), and nothing is unchangeable. Even the past is vulnerable to re-storying to change its meaning and change its effect on the present.

Cecchin *et al.* (1994) suggest that the therapist's own story affects the development of the client's story and their ideas about the therapist's personal views or 'prejudices' develops earlier positions of neutrality and curiosity. Cecchin *et al.* advocate openness about and accountability for the therapist's prejudices as a way to minimize attempts to control clients. Unlike narrative ideas which tend to obscure therapists' prejudices (Keeney, 1994), coming clean about views that you cannot be neutral about or irreverent towards (Cecchin *et al.,* 1992) is more honest, they say, and the relationship between the client's and the therapist's prejudices - which is the therapeutic process - is acted out in full view.

Second order ideas demonstrate a comprehensive and detailed consideration of the weaknesses in our first order thinking. They show a preoccupation with matters of ethics, pragmatics and the wider ecology of ideas. Radical ideas demand radical behaviour and these ideas challenge contemporary therapeutic thinking and practice. Second order theorists make claims like 'events have no existence outside of us defining them' (Kfran and Lukens, 1985), 'objectivity avoids responsibility' (Mason, 1991), 'directive therapy models are pathologising' (Hoffman, 1993), 'moralising is taking a power position' (Hoffman, 1993) and 'life is purposeless — purposes are only observers' attempts to give meaning' (Efran and

Lukens, 1985). Such statements evoke responses ranging from outrage and cynicism to excitement and relief, depending on your view of these ideas and the implications they hold for your practice.

What would second order practice look like:

Therapeutic practice that is completely non-hierarchical, non-instrumental and non-pejorative would be like complete neutrality - certainly unattainable and probably undesirable. Nevertheless, a move towards these principles is a move towards more second order practice (Hoffman, 1993). As with questions that are best considered as more or less circular rather than either circular or linear, practice is best considered as more or less second order. No technique is second order in itself but it is the intention of the therapist that makes it so. Giving advice, for example, is only first order if you intend the other person to take it (literally or paradoxically). Despite this, most actions betray the intentions of the actor and some actions more than others clearly intend less hierarchy, less instrumentality and less attribution of fault.

1. Regarding therapy as a particular kind of conversation. Many therapist skills are conversational skills, and good conversation - like second order systemic therapy — is likely to be non-hierarchical, non-instrumental and non-pejorative. We are more likely to want to draw out the other's story than to impose our story about them. Listening may be more helpful than talking, asking questions more helpful than making statements, and trying to understand more helpful than trying to change. Be wary of any kind of planned 'intervention' — it may feel disrespectful and manipulative to the recipient. 'Conversational' is the less hierarchical context you are trying to create.

2. Influencing the context, not the people. It is preferable to be instrumental in establishing the context for therapy — the room, the culture of listening and talking, the curious, exploring approach, etc. — than to be instrumental in therapy. As professionals, we can reasonably be responsible for this and for forging a good structural coupling with our agency and our clients - one which enables us to invite the family to use this context and to comment on its effect. Organisms thrive in settings designed to let them thrive, and an ability to alter the environment to suit the (family) organism is an advantage we have. Where meetings are held, who comes, what is discussed and how, how any supervision is organized - all these should be flexible in the service of the conversational needs of the system. Wisdom leads therapists to respect the conditions necessary for systems to function (Atkinson and Heath, 1990) and respect will always be more important than knowledge in dealing with systems. In a therapy context, knowing what to do may only mean having principles about how to behave respectfully.

3. Focusing on ideas and meaning more than behaviour. Exploring ideas and meaning may feel less pejorative than exploring behaviour, and this may allow consideration of issues that might otherwise have been Impossible. For example, focusing on a client's idea that they must control others in order to be content is likely to be more helpful than focusing on the actions of trying to control them (Atkinson and Heath,' 1990'). Of course, moving the focus from behaviour to meaning can make precise discussions difficult, but this very vagueness allows new thoughts and ideas to emerge from the shadows for consideration.

Ros Draper (personal communication, 1992) emphasizes the importance of altering the definition of the problem at an early stage in therapy. The original definition is likely to contain pejorative meanings that constrain thought, whereas a new definition will have new meanings leading to new behaviour. Therapy can be seen as an exercise to explore new meanings until old meanings are lost (Campbell, 1990). Labels (i.e. old, usually pejorative meanings) applied to people can be profoundly damaging - Hoffman (1993) reckons that 99% of the human suffering she sees emerges from the labels attached either by others or by people about themselves. But labelling yourself amounts to defining your identity, and what would you be — would you even exist without this?

4. Adopting a horizontal stance. Good conversation occurs most often where there are horizontal, i.e. collaborative rather than hierarchical, relationships between participants. Therapeutic conversations may not be between 'equals[1] (whatever that is) but they should be encouraged to go in clients" preferred directions. Hypotheses — which reveal the therapist's preferred directions - are best forgotten once you enter the therapy room.

A horizontal stance does not deny your expertise in all sorts of matters; it's just that, as far as how the present problem might be resolved is concerned, you are unlikely to know best, and adopting an expert position is an attempt to persuade the family that you do. One-way screens, one-way messages and hidden teams are trappings of the expert and unless you adopt these because the clients wish you to adopt the expert role (thus giving them some control over the kind of therapist they need) they can tempt you into behaving like experts and believing you do know best.

If you regard yourself as an expert it may be reasonable to act wilfully and to try to impose your will on others - after all, an expert probably knows how to solve their problems. Letting go of such wilfulness ourselves and creating a context that supports others letting go of their wilfulness invites our clients to share our second order frame.

It is surely impossible to abandon wilfulness altogether - for example, trying to rebalance situations that appear out of balance may seem like a traditional structural manoeuvre, but who does not try to maintain a

balance between participants' contributions in therapy? A second order frame would view wilfulness as mostly unhelpful if unavoidable. However, when we find ourselves acting wilfully we can

(1) Monitor how much our wilful behaviour is driven by our own wishes and how much by clients' wishes.
(2) Try to avoid relying on the imposition of our will to achieve change. Additionally, it is important to avoid relationships with clients where we rely on them co-operating with our wilfulness(and thus to act will-less themselves). Client compliance is a cause for curiosity if not concern.

Friedman (1987) says 'the key to most cases is getting at least one member to let go of their wilfulness' (although 'getting' someone to let go of wilfulness sounds rather like paradoxing the therapist). It matters less which position (or non-position) we take, than our readiness to abandon it for a more useful one.

5. Using reflecting teams and other practices that fold ideas back on themselves. The reflecting team intervention (Andersen, 1987), whereby the observing group either emerges from behind the screen or swaps rooms with the family to discuss their ideas in front of the family is probably the best known and most used technique of a second order approach. Many therapy teams have developed their own styles for this while keeping to Andersen's guidelines which suggest:

The team shouldn't discuss their ideas with each other beforehand.
Use both/and or neither/nor frames rather than either/or.
Use speculative language.
No more than four people reflecting.
Between one and three reflections per session.
The family and interviewer should have the last word.
No negative connotations.

The family's discussion is folded back on itself (Hoffman, 1993) as family members listen to the effect it has on the observing group. The family now become observers to themselves and, when asked for comments on the team's discussion, another fold is made. The process minimizes expertise while preserving difference and encourages a collaborative co-creative approach. Not having to respond frees up the way people listen as there is no pressure to formulate any ideas or words, no pressure to have a position. At the end of the session Kazan et.al. (1993) suggest that the reflecting team and family join together to interview the therapist about their questions, thoughts and attitudes. In this way, a different aspect of the interview is folded back,

Campbell (1990) suggests a similar model for discussions behind the screen during session breaks. After listening to the therapist's thoughts the team discuss their own while the therapist listens, finally choosing the ones to pursue further. Most therapists seem to like this, as it retains a sense of control over the direction taken while still giving access to different ideas. The therapist's comments are not sought just for the team to demonstrate respect but as the basis for their subsequent comments. This protects the team from planning the discussion.

Circular questions, with their ritual of asking a question based on the previous response, is another folding technique that, in principle, qualifies immediately for second order status. Questions which connect ideas together (e.g. dyadic questions, future orientated questions, reflexive questions) also get called circular. When questions come less from the current conversation than from the therapist's personal hypotheses they lose their folding nature but may still be non-instrumental, non-hierarchical and non-pejorative.

6. Considering neutrality and evolving new interpretative positions. While 'neutrality' has had a bad press, any therapeutic stance that, through curiosity (Cecchin, 1987), encourages the constant evolution of new interpretative positions is going to look similar (Anderson and Goolishian, 1988). Other elements central to a therapeutic conversation suggested by Anderson and Goolishian which fit a second order frame include:

- Keeping the enquiry within the parameters of the problem as the clients describe them.
- Entertaining multiple and contradictory ideas simultaneously.
- Choosing co-operative positively connoting language.
- Listening respectfully and not understanding too quickly.
- Maintaining a conversation with yourself about the conversation with the clients.

The usefulness of any new interpretative position to a therapeutic conversation is in its viability, in the fit it makes with family members' stories (Hoffman, 1993). As with most stories, some elements or experiences do not fit neatly into the meanings generated. Clients can be invited to suggest meanings out of such incongruent experiences, thus intervening in their own problems to make new meanings and a new story (Zimmerman and Dickerson, 1994).

7. Using your prejudices, being curious, uncertain and irreverent. Cecchin, either on his own or together with

Lane and Ray, continues to generate inventive and challenging ideas that push earlier Milan ideas into a second order frame (Cecchin, 1987; Cecchin et al., 1992, 1994). Ideas about, in particular, curiosity, irreverence, uncertainty and prejudice constitute a set of guidelines about thinking and behaving for the aspiring second order therapist, and can stop us from trying to impose the 'right' interpretation or the 'true' meaning on other's behaviour or the 'correct' changes that need to be made. Prejudices describe the positions we take and how to use these positions responsibly and creatively. Curiosity describes the orientation generated when we can move easily between positions. Doubt is a useful internal restraint when faced with unquestioning beliefs, assumptions or meanings. Irreverence to all theories protects us from a single-minded approach to families.

Prejudices may only be pre-existing thoughts, but our pre-existing thoughts are what constitutes our being. Once again, Cecchin chooses a word that risks being negatively connoted but there is no implication that our prejudices are unjustified or erroneous. Therapy involves a constant exchange between therapist and clients and their prejudices are what get exchanged. Each word, each action, each meaning intended reveals the prejudices of their author. Typical prejudices held by therapists include:

Parents should be in charge of children.
Open communication leads to better relationships.
Gender inequality is the source of many problems.
Second order ideas are better than first order ideas.
Families should be allowed to develop their own styles of functioning.

Renaming ideas and beliefs as prejudices encourages us to maintain doubts about them and to act irreverently towards them. As therapists, we owe it to our clients and to good practice to be made aware of our prejudices and to be accountable for how we display them. Such a description of therapy builds on previous ideas about hypothesizing, neutrality and circularity (Selveni Palazzoli et al., 1989) which emphasized a 'scientific' approach. Prejudices emphasize the person and the personal in the interaction and these ideas enable us to evaluate and account for the therapists' biases as well as their skills.

Which ideas, practices and language should the 'becoming' second order therapist consider letting go of?

Ideas challenged by second order thinking include: Homeostasis; triangulation; circular (let alone linear) causality and 'circularities', Symptoms having functions; family beliefs; existence, truth, facts, right and wrong; objectivity and, thus, subjectivity; changing people (except ourselves); categories of problems; empowerment; the life-cycle; therapists 'knowing' something about someone else; meta-positions; fault.

Practices challenged by second order thinking include: Discussion away from the family; critical language; acting or talking as if we understand or know; 'strategic' interventions; interpreting; attempts to change behaviour; wilfulness.

Words and phrases challenged by second order thinking include: 'What she needs is . . .'; 'What's going on is . . .'; 'The fact is…'; 'overinvolved'; 'enmeshed'; 'dysfunctional'; 'Why can't he see that . . .'; 'The family want/think/believe/feel . . .'; I understand'; most words that begin 'dis…

Such a list somehow leaves us with less than we started with and seems to make the adoption of second order practice more a process of 'giving up' and 'taking from' rather than 'adding to', and this is one of the problems.

The problems with a second order approach

First and second order ideas - a case of 'both/and' or 'either/or'?

Simon (1992) believes a schism has been created between first and second order ideas as a result of the literature that distinguishes between the approaches. He criticizes Anderson and Goolishian for writing about how family therapy is moving in two opposing directions (1988) and how the two understandings are mutually exclusive and opposed (1986). Such a framing, says Simon, 'betrays the systemic foundations of the field'.

The idea of integration is attractive so long as it is truly inclusive of both ideas. An integration that is less than a 'both/and' combination has little more to commend it than either of the original ideas. In his article, Simon discusses his 'both/and' integration of the two approaches, using an analysis of language and the way it is used. Atkinson and Heath (1990) also discuss their integrative model of first and second order approaches, describing how each model is used to generate ideas which inform the other such that 'interventions' are a result of both ways of thinking.

My uncertainties about the feasibility of such 'both/and' integrations reflect doubts about the assumed advantages of integration over non-integration, doubts about how much of each philosophy has actually been integrated and concerns about the limits of the 'both/ and' frame. Now reframing 'either/or' situations into 'both/and' can be an immensely creative move. It avoids challenging ideas directly or setting them in competition with others. It invites people to think not 'whether' but 'how' an integration is possible. But, of

course, such a sleight of hand does not make an impossible integration possible and the merits of the 'both/and' position should not fool us into thinking that adopting an integrated perspective can always be achieved without having to give up anything. Thus far, attempts to integrate the two seem to retain substantial normative thinking and look more like an addition or a summation than an integration, with the 'integrated' theories alternating between first and second order positions along with important aspects of each theory being given up in the quest for integration.

Many personal philosophies are so strongly held that they make an integration with second order ideas possible only up to a point; Feminist discourses, for example, often reveal uncertainty about embracing these ideas. Goldner (1993) seeks ways to help us to 'retain a second order perspective while simultaneously grapping with, the reality of social hierarchy and inequality'. Such a statement reflects both a wish to use second order ideas and a commitment to a 'reality' that seems beyond question. While few of us might personally doubt the existence of social hierarchy and inequality, taking a second order stance in therapy would require a curious, doubtful and irreverent approach to this prejudice. If an irreverent approach to our beliefs seems impossible then we can, at least, protect our second order credentials by considering ourselves prejudiced in the matter. Neither putting 'reality' in parenthesis nor accepting it as a personal prejudice (for example, by preceding it with a personal pronoun) means a first order view is being taken.

An alternative to integration is Speed's view (1991) that reality exists but we cannot fully know it. This is similar to Kelly's view (1980) and, while seeming fundamentally different to second order theories, might look similar in practice. Both would, I believe, look for the reality that our clients construct and how well this serves them. Such practice accords with Hoffman's principles of non-hierarchical, non-instrumental and non-pejorative therapy. If we can only know reality through our construction or mediation of it, how much difference does it make, in a therapeutic context, whether it exists or not?

Pocock (I993) discusses a position which harnesses modern and postmodern ideas. He suggests a 'better story' concept that uses some narrative ideas without accepting what he regards as the postmodern view, that all stories have equal validity. Frosh (1995) suggests that a 'better narrative' is not possible under postmodern conditions. In my view, however, better stories or narratives seem quite in keeping with second order ideas which do, of course, accept all ideas but do not imply that they are all equally useful. A similar mis-inference was, I believe, made about circular causality, where 'everyone playing a part' was taken to mean that everyone played an equal part or everyone was equally responsible. To regard all ideas or behaviours as equally useful would make action no more valuable than inaction and prevent movement in any direction. Such a stance may be one interpretation of second order ideas but it is of no use to a therapist, and I know of no one who advocates it.

Perhaps my pragmatic attitude towards reality is not very second order?

Theoretical and communicational problems

Criticisms of second order ideas have focused mainly on 'narrativists'. Goldner (1993) criticizes the conversation metaphor of Anderson and Goolishian (1988) for its 'laziness' and 'lack of moral clarity'. Cecchin et al. (1994) describe how they failed to master the narrative approach as described by Andersen (1987), White (1989) and Hoffman (1993). They called it 'the art of how not to do anything', and cited their inability to control their thoughts and prejudices as the problem. Keeney (1994) suggests that 'narrativists' risk proceeding towards the impossible goal of working without prejudices and that such a therapist should probably not be created or imagined.

Even Lynn Hoffman (1993) - whose current practice shows an uncommonly clear adherence to second order ideas - talks about how she will make a moral point or intrude strong moral positions. Does 'knowing' which practices are moral and which are immoral not amount to taking a (morally) hierarchical position? Do these views amount to any more than a personal prejudice? If so, should we then not develop uncertainty and irreverence towards these ideas and try to protect our clients from them?

We could argue that all views are personal prejudices, and that only by endowing views with something more substantial (for example, calling them 'facts' or collecting 'evidence' to support them) are we able to act more confidently on them. How will we know what to do if we give up empirical positions (Anderson and Goolishian, 1988)? If nothing is true, there is no reality and we cannot influence people to function better, what is the point of anything, let alone therapy?

Every action has an intention and this intention is, however subtly, an intention to influence or control something. Such conscious strategizing is inevitable - as are the making of normative judgements.

Is it really possible to strategize and judge without trying to influence or control people (Atkinson and Heath, 1990)? Our agencies are organized on the assumption that you can influence others in predictable ways. The idea that we should give up trying to control people just because it does not work fails to take account of the vested interests in maintaining 'controls'.

Professional problems

Most of us have been taught counselling skills and while each discipline has its favourite approaches to therapeutic change, family therapy is unlikely to figure largely. Yet rarer would be a course that looked at second order systemic ideas. Given the knowledge and skills that most disciplines in training are bound to cover, how

appropriate is it anyway? How would it help a newly qualified psychiatric nurse to know about reflecting teams? What would a student social worker tryi n g to understand care management make of Maturana's ideas .Or the impossibility of instructive interaction?

Most professions have traditional orientations that become well-known stereotypes. These are generally areas in which the profession has greater expertise than do other professions and they thus come to form part of its identity. Social workers take children into care, psychiatrists give out drugs, psychologists conduct behaviour programmes, occupational therapists make baskets — we all know them. As none of these professions is yet associated with systemic ideas we are l i k e l y to continue coming into this work with the first order views of life, reality, knowledge, etc. that predominate in our original training. These trainings make assumptions about what a healthy family is like, what 'normal' is, what to do to be helpful, how to get people to change and the kind of changes that will best help clients. They assume that objective assessments can be taken, plans and strategies made, targets set and people motivated to change in desirable ways. If we have received some training in therapeutic models it is likely to be in behavioural or analytic approaches that make some of the same assumptions. If we were lucky enough to have access to some systemic teaching it is likely to have been in an early family therapy model that may make similar assumptions. (This may be just as well because second order ideas might seem bizarre or disorientating in the context of basic professional training.)

Given that we are trained to believe that we can change clients it is hardly surprising that we try. If this does not have the desired outcomes, we can be tempted towards explanations that do not include us in the frame, for example client 'resistance', 'lack of motivation', clients 'not being candidates for change'. Sometimes it will seem as if we have changed our clients and occasional 'successful' outcomes are important (and inevitable). They offer evidence for the theories' correctness until the next workshop or training course can boost enthusiasm to a more self-sustainable level. Growing experience is likely to increase your grasp of the model and improve your relational and general interviewing skills. Greater listening and conversational skill is likely to lead to better client feedback and, with time, your identity will become increasingly linked to your chosen model, making change harder. Such a process applies as much to family therapy as any other therapy, and tells us nothing about a model's usefulness. Of course, a second order view would be that models have no inherent value and the meta-style of a second order approach certainly does not require us to do family therapy.

To employers, the theories we choose matter less than their demonstrable usefulness and value for money. If second order ideas are not measurably more effective in helping agencies with their (usually instrumental) tasks then we cannot expect their support. Thus behavioural and solution focused approaches which combine the advantages of clarity, simplicity, optimism and relative measurability are not surprisingly winning support among those who have more concern for action than elegance. Second order ideas are just too radical, too complex and too vague for most agencies to entertain. Agencies rely on the political and cultural viability of their theories for their continuing existence and this can make it hard for them to doubt existing first order prejudices. A problem for therapists then becomes how to practise second order therapy within a system that holds and enacts first order beliefs.

For professionals to give up thinking that they can directly influence their clients will, for some, be to question the point of being a therapist. Clients come assuming we can influence them and if they believed they were structurally determined some may likewise doubt the point of coming. From the time they say, for example, 'I want Johnny to stop stealing', we engage around the assumption that we can help him stop stealing. Should we tell them that we cannot? Or do we really believe that we can? Even if we say 'He will only stop when he decides to' - which sounds second order enough - there is still an assumption that we can help him want to stop. If we came clean with our clients about second order theories we hold, would clients have more or less confidence in us?

Furthermore, what about the confidence our students and trainees m i g h t need to have in us? Trainees often need certainty of beliefs in older to learn (Cecchin *et al.*, 1994) yet we are advocating uncertainty about everything - even about the usefulness of uncertainty itself.

Other problems

In earlier debates about 'neutrality', the moral position in second order thinking resembles something akin to amorality which is experienced by many as immorality.

So long as conflicting ideas exist about what is the most moral position to take, any moral position becomes partiality. For example, w h i c h of these positions is more moral?

- Being useful (Which is what exactly)?
- Supporting the weak against the strong (And are we sure which is which):'
- Working with the family's morality (Except that there is probably a Variety).

* Actively using your personal moral positions (Which may be immoral)

* All of these positions somehow integrated together?

* Alternating between these positions?

We all take each of these positions at different times but uncertainty about the 'right' position is likely when we experience conflict between 'head' and 'heart' messages about how to behave. More training may help us to develop more resistance to certain heart messages in the cause of 'effectiveness', so is this then more ethical? Most religions would have problems accepting that such conflicts are only our constructions, and that our attempts to give meaning were no more than personal or social constructions. If there are fundamental conflicts between religious ideas and second order ideas, where does this leave therapists who believe in both? Presumably some accommodation is made where, as with other 'truths' held by individuals, second order ideas are acceptable up to a point.

As human beings, it seems impossible to avoid strong views about what should and should not be and we only seem able to see a proportion of these views as prejudices. The rest of these views we hold as 'truths'. At each point of contact between such truths and a therapeutic conversation the non-judgemental position is lost, and the non-hierarchical and non-pejorative bits seem to quickly follow. When our wish to represent the truth becomes stronger than our wish to maintain a (presumably more helpful) second order stance, the most we seem able to do is to move to and fro between first and second order thinking. This is alternation, not integration.

Pure first and second order positions both represent extremist thinking and each have reasonable grounds for regarding the other as unethical. However, when we fail to make a good fit with a first order culture it is less because of our second order prejudices and the inadequacy of these theories than because of our failure to apply them wholeheartedly. Such a failure is a direct consequence of the problems in using second order ideas in a culture which enacts first order beliefs. This dilemma leads to first order (masquerading as second order) behaviour such as:

- Criticizing colleagues for being judgemental of their clients.
- Trying to persuade colleagues of the superiority of second order ideas.
- Failing to take clients seriously when they ask for advice.

Major struggles with a second order stance also occur within professional relationships. The difficulties in attaining an observer-type position towards our colleague relationships (because they are so personal) added to the crucial importance of these relationships in influencing how we define and value ourselves make it harder to maintain a second order perspective here. It is more difficult to influence the agency's style than our therapy style.

One obstacle in the way of acting 'second order-like' in colleague relationships is the tyranny of 'right' thinking. Most workplaces have prevailing beliefs that purport to represent staff views and these can result in thinly disguised bullying and patronizing behaviour by those who represent the dominant discourse or story towards those who speak "in a different voice' (Gilligan, 1982). In some work settings sexist or right-wing prejudices tyrannize staff, whereas in our agencies it may be feminism or left-wing prejudices. Our preoccupation with acting helpfully and ethically (and ethically presumably only means 'helpfully having considered the wider and longer term implications') makes us sensitive to criticisms of 'non-Mchi iInnking or behaviour. These are the points at which we risk abandoning second order ideas for a 'more ethical position', and thus take higher moral ground. As all moral positions are inherently judgemental, they fail to achieve second order status.

Examples of second order-like behaviours in professional relationships

- Trying to understand the story behind colleagues' views.
  Anticipating future agency pressures in order to positively connote them and find creative ways to relate to them.
- Avoiding negatively connoting colleagues who negatively connote

  Trying to demonstrate practice rather than claiming it.
- Positioning students and clients as first level observers and commentators of our practice.
- As managers, offering leadership when staff lead us to it.
- Regarding our views as prejudices and biases.
- Focusing on what we can learn rather than what we can do or show.
- Stretching ourselves to teach in order to help us learn.
- Practise behaviours which we should like to adopt as habits

Of course, some actions by employers (for example, threats of major change to our jobs) will make it impossible to behave in such ways as important instincts for survival will commit us to a fight. When personal losses are threatened a second order position becomes inaccessible as we are impelled to behave wilfully to protect ourselves.

We cannot always afford to wait for the rebalancing of the larger system over time.

Conclusion

It is all too tempting, under pressure, to abandon second order lili.iM mil ieveii lo old habits from our behavioural or analytical luiltiun I lie le.isl we should expect of newer ideas is that they are realistic about the difficulties they create for their users. Exponents of second order ideas have yet to do this adequately, some seeming to rely on elegance for achieving acceptability.

Attempted integrations of first and second order ideas fail to achieve a 'both/and' synthesis, looking more like the front end of one animal tacked on to the back end of another rather than anything containing the best features of both. Given our first order culture, second order ideas understandably make a worse fit with the worlds of many people.

Disagreements about the place and treatment of morality and power remain between those advocating a more second order approach. Some would view it as essential to support the 'good weak' against the 'bad strong'. Others would question the assumptions behind such a statement. While the most second order therapeutic responses to 'abusive' situations seem likely to be uncomfortably reminiscent of neutrality, it is not always tenable to take this stance and wait for the natural systemic rebalancing to support the 'good weak'. Too much damage may be done in the meantime. Such issues preoccupied the United Nations in its interventions into the former Yugoslavia.

It is not that major disagreements exist about what is ethical or unethical behaviour, but being 'useful' is, for some therapists, often different from and more important than being 'right'. Some would start calling their views 'prejudices', while others were still happy continuing to call the same views 'reality'.

Second order therapy may not, as Anderson (1987) suggests, be ideal therapy, but it is nevertheless hard to think of ways in which it is less ideal than a first order approach. Some criticisms of second order practice reveal similar misunderstandings which critics of earlier Milan ideas made by assuming that amorality means immorality, unusual means incomprehensible, complexity means vagueness, and not controlling means not caring. A family who, for example, said they wanted 'structural family therapy' would be likely to receive a similar approach from a second order therapist or a structural family therapist but the former would be acting on behalf of the family's wishes rather than their own. The second order therapist temporarily a structural family therapist - would explain that this stance was being taken because they wished it, thus insisting that the family shared responsibility for any progress or lack of it.

Most of us probably aspire to a more second order approach, but find it hard to sustain when it comes into conflict with pressures from the different cultures and contexts that we inhabit. Second order ideas do not amount to a blueprint for relating to the world - only an often difficult way of doing therapy - and this seems destined to keep them in a minority preoccupation. Although I hope not.

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