CONSTRUCTIVE HYPOTESIZING, DIALOGIC UNDERSTANDING AND THE THERAPIST'S INNER CONVERSATION: SOME IDEAS ABOUT KNOWING AND NOT KNOWING IN THE FAMILY THERAPY SESSION

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The primary tasks of the therapist can be described as listening to what the client says and making space for what the client has not yet said. According to Anderson and Goolishian, the therapist should take a not-knowing stance in this dialogic process. The question remains, however, what not-knowing exactly means. In this article, I will explore this question and I will propose the concept of constructive hypothesizing. Constructive hypothesizing is described as a process in which there is a movement back and forth between knowing and not knowing. Of central importance are creative and dialogic understanding, rather than knowledge. Recommendations are made to ensure the constructive and collaborative use of hypotheses in the therapeutic dialogue.

“There’s no alibi for being.”
(Mikhail Bakhtin, in Morson & Emerson, 1990, p. 31)

In the last 2 decades, the constructivist, second-order cybernetic, social-constructionist, and postmodernist philosophies have led to important epistemological evolutions in the family therapy field. The representational nature of knowledge, the idea that knowledge is some kind of representation of a real world out there, was challenged. Knowledge, even scientific knowledge, could no longer be accepted as the truth because there is no objective reference point from which to observe the world. These epistemological ideas had important consequences for family therapy practice. If there is no objective reference point from which to observe reality, the knowledge of the therapist (observations, ideas, theories, and so on) is called into question. This started a move away from the field’s earlier preoccupation with observable relational patterns and family structure toward an interest in stories and conversations (Paré, 1996). The therapeutic process was described as a conversation in which the therapist listens to the client’s story and makes room for the not-yet-said (Anderson & Goolishian, 1988). In this way, a new paradigm developed in family therapy. It could be called a narrative paradigm or a language-based paradigm, because the basic metaphors used in this paradigm are language metaphors like narrative, story, conversation, and so on.

This new paradigm, however, was not catalyzed solely by an epistemological concern. It also represented a response to the problem of power that has been present throughout the history of family therapy (Rober, 1997), and even has been called the epistemological core of family therapy (Rabkin, 1978). In response to these discussions about power, the proponents of the narrative paradigm made a fundamental ethical choice: Therapeutic conversation was to be a dialogue in which a therapeutic relationship of partic-
ipation and collaboration was favored. This choice for dialogue was at the same time a choice against a technical, hierarchical, or interventionist therapeutic relationship. In this sense, the narrative or language-based therapy could also be called collaborative therapy (Strong, 2000), because it favors a therapeutic relation of collaboration (Anderson, 1997), participation (Hoffman, 1991), and coauthorship (White, 1991).

**DIALOGUE**

A therapeutic relationship of collaboration and participation is sometimes understood as a relationship characterized by an extreme respectfulness in which only the view of the client is important, and in which the therapist as a person disappears. For instance, some authors state that the therapist should enter into the world of her clients and see life through their eyes, or that she should try to put herself in the shoes of the people with whom she works (Freedman & Combs, 1996). In the same vein, other authors state that all a therapist has to do is “just listen to what the client says” (de Shazer, 1994, p. 109). Although it is undoubtedly important that the therapist listen to what the clients say, this is not enough to create a real dialogue.

Dialogue is a keyword in the philosophy of the Russian social philosopher and literary theorist Mikhail Bakhtin (Bakhtin, 1981, 1986; Morson & Emerson, 1990; Shotter, 1993; Shotter & Billig, 1998). He states that every utterance (verbal or nonverbal) is addressed to someone and acquires its meaning in the context of the relation with others. According to his view on dialogue, the listener is not a passive receiver of a message. To the contrary, both speaker and listener are active participants of the dialogue. The words of the speaker are not just received, they are met and welcomed by the inner voices of the one who listens. The words resonate in the inner conversation of the listener; they evoke something, all while the listener is preparing a response.

A dialogical view of the therapeutic relationship, then, implies that not only the clients, but also the therapist are actively present in the conversation. The therapist does more than listen passively to the story of the client. Mere empathic listening is only one step of a dance that is much more complex. If the therapist’s task would be restricted to only listening, then therapy would merely be duplication and would not lead to anything new or enriching for either side. As another step of this dance, the therapist initiates a dialogue with the family in which there is room for creative understanding.

Creative understanding is the term Bakhtin (1986) used to refer to a special sort of dialogue in which a meaning of one person comes into contact with another meaning of another person. This dialogue results in valuable new meanings that are different from the two original meanings. Because it is necessary that the two original meanings differ sufficiently, Bakhtin (1986) stresses the importance of outsideness in creative understanding: “[I]n order to understand, it is immensely important for the person who understands to be located outside the object of his creative understanding.” (p. 7, italics in the original). Only difference or being outside creates the possibility for an enriching dialogue. In the therapeutic conversation the therapist’s outsideness is often reflected in the questions that are evoked in the therapist’s inner conversation (Robe, 1999). As Bakhtin (1986) wrote: “Without one’s own questions one cannot creatively understand anything other” (p. 7, italics in the original). The therapist’s questions are crucial tools to make room for the family to say the not-yet-said and generate new meanings. In this way, the therapeutic conversation becomes a dialogue in which not only the clients but also the therapist is an active participant, and in which their encounter enriches both of them. Creative understanding adds outsideness to empathy in such a way that the complex dance of the therapist and the family becomes one of both closeness and distance, intervention and reflection, listening and action.

**NOT KNOWING**

In this dialogical context, one in which the therapist chooses a relationship of participation and collaboration, the knowledge of the therapist becomes not only an epistemological problem, but also an ethical one. Therapeutic expertise creates a hierarchical relationship, because the knowledge of the therapist gives the therapist power over the client. How can a therapist have a collaborative relationship with clients if a
therapist is an expert with expert knowledge? In an attempt to give an answer to this ethical dilemma, the concept of “not knowing” was introduced by Anderson and Goolishian (1988, 1992). “Not knowing” refers to a stance in which the therapist communicates a genuine curiosity for the client’s story. The therapist does not know a priori, but listens to the client’s story, takes the client’s story seriously and joins with the client in a collaborative exploration of her experiences: “Not-knowing requires that our understandings, explanations, and interpretations in therapy not be limited by prior experiences or theoretically formed truths” (Anderson & Goolishian, 1992, p. 28).

It is clear that Anderson and Goolishian’s concept of “not-knowing” (Anderson & Goolishian, 1992) does not refer to the therapist’s “knowing nothing” or to the therapist’s mind as a tabula rasa. On the contrary, Anderson and Goolishian (1988) explicitly state that the therapist maintains an inner conversation with him- or herself. There is a clear connection between not knowing and the therapist’s inner conversation because maintaining an inner conversation “means that a therapist makes room for the other by not entering with formed ideas and plans about client and the problem or its solution” (Anderson, 1997, p. 128). This connection between not knowing and the therapist’s inner conversation may not be self-evident, but it can be better understood when one considers the inner conversation as a polyphony of heterogeneous inner voices (Bakhtin, 1981; Voloshinov, 1973). The inner conversation is not a monologue (or a knowing), but a dialogue among many voices that can be very different and even often are contradictory. In that way, the not-knowing stance is reflected in the therapist’s inner conversation.

NOT KNOWING AS AN ETHICAL IDEAL

Inspired by his study of some recent writings of Jacques Derrida, Glenn Larner (1995, 1996, 1999, 2000) addresses the complexities of knowledge and power involved in a not-knowing stance. Larner (1995) joins Anderson and Goolishian (1992) in their ideas about not knowing, but he stresses that not knowing is a powerful knowing at another level, because the not-knowing stance presupposes an expertise on the part of the therapist: “Not-knowing is the therapist’s expertise… so as to influence [the family] to find their own meaning in understanding their problem” (Larner, 1996, p. 426). The not-knowing stance does not dissolve the expertise of the therapist in the therapeutic session. Larner (1996) adds: “In the therapeutic conversation… therapists cannot avoid positions of power and knowing” (p. 427). It is not possible for the therapist to have no interpretations, ideas or thoughts about what happens in the session, and every interpretation, idea or thought of the therapist is culturally, politically, or gender informed. Larner (2000) states: “A critical not-knowing acknowledges a collaborative stance as an ethical ideal tainted by power, knowledge and social hierarchy in the therapeutic context” (p. 69). So the therapist’s knowledge and power are inescapable in the therapy practice, and it is the ethical task for the therapist to find ways of using knowledge and power as a basis for dialogue and open enquiry, for the sake of the client’s own knowing and empowerment. Power and knowledge are not renounced, but linked to an ethic of responsibility (Larner, 1999).

This view of not knowing, in which the therapist uses knowledge as a basis for dialogue, is not in contradiction with the ideas of Anderson and Goolishian (Anderson & Goolishian, 1992). Anderson and Goolishian’s concept of not knowing does not challenge the idea that therapists have prelearned knowledge— theoretical and experiential, professional and personal (Anderson, 1997). They describe the therapeutic conversation as a circle of meaning in which the therapist’s knowledge is the base of therapeutic questions that invite the clients to tell their stories, and the clients’ stories again sculpt the therapist’s understanding, which raises new questions and new invitations (Anderson & Goolishian, 1992).

THE CONCEPT OF HYPOTHESIS

Although there are a lot of theoretical and practical differences between the approach of Anderson and Goolishian (Anderson & Goolishian, 1988, 1992), and the Milan approach (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980), this view of the circle of meaning is not incompatible with the view of the Milan team on the therapist’s knowledge. Both Anderson and Goolishian (Anderson & Goolishian, 1988, 1992) and the Milan team highlight the relativity of the therapist’s knowledge. The Milan team from a Batesonian,
cybernetic perspective, and Anderson and Goolishian (1988, 1992) from a postmodernist/social constructionist perspective. To refer to the therapist’s knowledge, the Milan team uses the concept “hypothesis,” which is defined as a supposition tentatively accepted to be a guide for the therapist in the session with the family (Selvini et al., 1980). In their view, not the truth status, but the usefulness of the hypothesis is of central importance: “The hypothesis as such is neither true, nor false, but rather more or less useful” (Selvini et al. 1980, p. 5). In other words, a hypothesis is not a theory that attempts to capture the truth, but a tool that the therapist can use in trying to open space for the not-yet-said in the conversation. This definition of a hypothesis is very different from the way it often is defined as part of the process of scientific inquiry, in which it serves as a means of scientific evidence gathering through a process of validation or falsification (Sandler & Hulgus, 1989). In the definition that is used in this article, the purpose of a hypothesis is not to find a scientific explanation for the problems in the family. Rather, the purpose of a hypothesis is to facilitate understanding (Sandler & Hulgus, 1989).

**DIALOGIC UNDERSTANDING**

According to John Shotter (1993), understanding is an active process of negotiation in which what is understood is constructed from vague fragments: Assumptions, tests of these assumptions, consideration of the circumstance of the utterance, the waiting for the next utterance that might clarify the first one, and so on. So understanding is not a representational process that passively reflects some inner, intended meaning of the family members. On the contrary, understanding is active, dialogic, responsive and unfinalizable (Morson & Emerson, 1990; Shotter, 1993; Shotter & Billig, 1998). To summarize: Understanding does not result from a passive receiving of unambiguous meaning. Rather, meaning is realized in the process of active understanding (Voloshinov, 1973). Understanding is dialogic (Bakhtin, 1986), in the sense that, although understanding can be situated in the therapist’s inner conversation, the therapist is not the only author of it. In the dialogue, understanding is jointly build up by the therapist and the family members. The therapist’s dialogic understanding is also responsive: It constitutes “nothing other than the initial preparatory stage of a response” (Bakhtin, 1986, p. 69). The therapist is preparing him- or herself to respond to what is being said in the conversation. The family members do not “expect passive understanding that . . . only duplicates his own idea in someone else’s mind.” (Bakhtin, 1986, p. 69). Understanding is also unfinalizable (Morson & Emerson, 1990). As Anderson and Goolishian (1988) write: “Understanding is always a process ‘on the way’ and never fully achieved.” (p. 378) There are always things that escape understanding and that remain a potential for meaning. These potentials might be revealed by further dialogue, but this dialogue would itself create new potentials that are not (yet) understood (Morson & Emerson, 1990).

**THE PROCESS OF HYPOTHESIZING**

The therapist’s attempts to understand the family members guide the therapist’s curiosity and questions in the session: “Without trying to finalize the other or define him once and for all, one uses one’s ‘outsideness’ and experience to ask the right sort of questions” (Morson & Emerson, 1990, p. 242). Hypotheses, suppositions tentatively accepted, help the therapist to focus on what seems most relevant at that moment. This is important because, more so than in individual therapy, so much is happening in a family therapy session that the therapist would be overwhelmed by a chaotic stream of information if she or he were to devote attention to every little thing that is said or done. The amount of information available at any given moment in the session is infinite. The therapist has to make some sort of selection, and this is where hypotheses become very useful tools. They organize all the confusing data attached to a symptom so as to make sense in the relationship context (Hoffman, 1981). Hypotheses give the therapist something to hold on to in the chaos of the family session, because they offer a sense of some coherence in the constant stream of ambiguous information (Ausloos, 1999).

This view on hypotheses can also be described from the perspective of the therapist’s inner conversation, conceptualized as a polyphony of heterogeneous voices (Bakhtin, 1981; Voloshinov, 1973). From such a perspective, hypothesizing is understood as a process in which there is a continuous movement in the
therapist’s inner conversation back and forth between knowing and not knowing, or between, what Bakhtin (1981) calls centripetal forces (pushing toward unity and order) and centrifugal forces (pushing toward multiplicity and diversity). The hypothesis narrows the focus and brings some unity and order in the polyphony of voices in the therapist’s inner conversation. But whenever the hypothesis no longer contributes to the therapist’s responsive understanding of the family, the therapist lets go of it. In that case, the therapist takes a broader focus and again listens to the multiplicity of inner voices. Hypothesizing, therefore, is a continuous process of moving back and forth between unity and multiplicity, narrowness and broadness, knowing and not knowing. These ideas are illustrated in the case story of Tim’s nightmares.

CASE STORY: TIM’S NIGHTMARES

Father called me to ask for an appointment. Father said he was worried about his 9-year-old son, Tim, who had a lot of nightmares. He was even afraid to go to sleep. It struck me that the father made this first phone call. I reflected: This is rather unusual. Most of the time mothers call. I wondered in what way this father was connected with the son. Was he just a very concerned father? Or did he feel that he had some responsibility in the son’s problems? Or maybe he is a sole father? Maybe his wife died? Then father spoke again.

Father: My wife and I are very worried. We don’t know how to handle this.
I reflected: So he is not a sole parent.
I gave an appointment to meet with the family.

During this telephone conversation, the therapist was struck by the fact that father called and he tried to make sense of it. In his inner conversation, three thoughts came to the forefront. Because these thoughts are three suppositions that were unproven, they could be called three hypotheses, however flimsy: Is he a concerned father? Does he feel in some way responsible for the boy’s problem? Is he a sole parent? These three hypotheses are brittle and premature. That is why the therapist did not use them as the basis for further questioning. The therapist instead chose to adopt an attitude of waiting and to ask open and general questions. This gave the client freedom to steer the conversation in directions with which he feels most comfortable.

In the first session I met with Tim, his father and his mother. Tim did not seem scared at all to be in this new situation. Mother looked quite relaxed too. Father, in contrast, seemed more tense. Again I wondered in what way father might be connected with Tim’s anxiety and nightmares. We talked a little bit and they told me that Tim has been scared to go to sleep for some months now. It started with his nightmares. I asked them to tell me more about that. Mother said that Tim woke up screaming for the first time a few months ago. Mother had gone upstairs to his bedroom, and Tim said he had dreamed that he woke up and found his parents to be gone. Mother comforted him and reassured him that they would always be there when he woke up.

Therapist: So that is what you do when he wakes up screaming? You go to his bedroom and you reassure him?
Mother nodded.

Therapist (addresses father): You also sometimes go to his bedroom to comfort him?
Father: No, I did once, but most of the times, she goes upstairs.

In this sequence the therapist poses two questions. The first question “Can you tell me more about that?” was meant to gain more understanding on how the problem began. It is an open question, which leaves a lot of room for the clients to answer whatever feels right for them. The focus of the second question is more narrow: “You also go to his bedroom sometimes?” The question was inspired by the therapist’s hypothesis that the father was concerned about his son. In the next sequence the therapist tries to gain more understanding of the father, but he is confused because the new information does not fit his hypothesis.
I reflected that it is striking that father said he did not go upstairs to comfort his son. Here was this father who phoned me because he was worried about his son, but when his son is screaming because he had a nightmare, he does not go upstairs to comfort him. This does not fit the image I have somehow made of the father. Maybe he was not as concerned as I had imagined in the beginning. I also wondered: what were father’s good reasons not to go upstairs to comfort his son? Was there something that scared him? Did Tim prefer mother to comfort him? If so, maybe father felt rejected.

Because I had so many thoughts and questions, I proposed to the family that before we would talk some more about their worries, I would first like to know them a little better. I asked them what they thought I would have to know about them to understand them better.

This sequence illustrates the delicate balance in the therapist’s inner conversation between knowing and not knowing, or in Bakhtin’s words (Morson & Emerson, 1990), between the centripetal forces, pushing for order, and the centrifugal forces, pushing for diversity. The therapist tried to understand the father by making a hypothesis, but at the same time he was sensitive to feedback from the family that did not fit his hypothesis. Because the therapist felt as if he did not understand the father anymore, he let go of his hypothesis of father being concerned for his son. He chose to be open again for the complexity and the diversity that is present in the conversation. Thus he asked another question: He asked the family members to introduce themselves. The way the question was posed is noteworthy. First, to have a broader perspective, the question was not directed at the father, but at all the family members. Second, the therapist gave the family members a lot of control: It is up to them to decide what they want to say. It is up to them to decide what the therapist should know to understand them.

Tim and mother gave the therapist more information about themselves. Then it was father’s turn. He said that his parents had died when he was a kid.

Therapist: How old were you exactly?
Father: 9 years old.
I nodded.
This made me reflect that Tim, too, was 9 years old. I wondered: Was this just a coincidence? Or was there some connection between Tim’s nightmare’s and some unexpressed feelings of the father concerning the death of his parents? Maybe I should ask him about it.

Therapist: Is it a coincidence that your son starts to have problems at the same age?
Father tensed.
Father: Yes, it’s a coincidence.
There was a silence in the room. Then father said he wanted to speak with me alone, without his son and his wife.

The hypothesis that there might be some connection between the death of his parents and Tim’s problems was offered for discussion to father. In that way the therapist checked if his hypothesis connected sufficiently with the family members’ thinking. When the father said “Yes, it is a coincidence,” this was only one part of the answer. Another part was his becoming tense. Father’s request to speak separately showed that the hypothesis had been a useful one. There came room for something new, because father asked to speak in a safer context. He seemed to contemplate showing some of his vulnerability.

The next session father came alone. He told me that his mother had died from cancer, and that his father had committed suicide shortly after that. Father talked about his sadness as a child and his loneliness. His father’s suicide had been very confusing for him. He also said that once when Tim cried in his bed, he went upstairs to comfort Tim, but when Tim started to talk about his nightmare of waking up all alone, father remembered how he as a kid woke up to find that not only his mother had died but that also his father was gone.

Father: That’s when I decided not to go upstairs anymore when Tim is crying.

The story father told the therapist in this session is further evidence of the utility of the therapist’s
hypothesis. The hypothesis clearly made room for a story that was not yet told. Furthermore, it helped the therapist to understand what were the good reasons (Rober, 2001; Tilmans-Ostyn, 1999) this concerned father had for not going upstairs when his son was crying. So the hypothesis of the concerned father was again accepted by the therapist, and in addition he started to think of father as a vulnerable man.

Father also said he was ashamed by his father’s suicide. That is why he never talked about it with Tim. In fact, Tim knew nothing at all about his grandfather. I asked what he thought might happen if he would tell the story to his son. Father replied that he did not want his son to have a negative image of his grandfather. Then I said that maybe he could share something positive about his father with Tim. Father liked that idea. We talked some more about this and then we decided that father would show some of his slides of the happy summer vacations he had had as a kid, with his father and his mother, before his mother became ill.

The therapist’s hypothesis underlying his suggestion to share some positive memories with his son was that the son expressed things in his nightmares that could not be said in the family. It was as if the father’s past and present were disconnected because the father wanted to protect the good memory of his father. The task of showing his son some slides of good moments with his father might help father to make some connection between his past (his parents) and his present (his son). It would only be a connection through positive memories, whereas the traumatic memories would remain unspoken, but it was a start. Maybe this connection would have some positive effect on the son’s nightmares, the therapist thought.

It is important to note that, although the therapist’s suggestion to the father was clearly inspired by the above-mentioned hypothesis, until the moment when the therapist asked the question he was not yet aware of his own hypothesis. This shows that hypotheses may be at varying distances from outward expression, and that, in fact, the relation between the hypothesis in the inner conversation and the therapist’s words is not one of simple expression. It often seems as if only through verbalization the hypotheses comes into being. As Vygotsky (1962) wrote in his book *Thought and Language*: “Thought is not merely expressed in words; it comes into existence through them” (p. 125). Indeed, verbalization is not just the expression of inner thoughts and ideas. The therapist was surprised himself when he suggested to the father to share some positive memories with the son. The words he used were not a mere expression of a hypothesis that he had completely worked out in his inner conversation. Instead, the therapist’s voice was guided by some tacit knowledge (Polanyi, 1975) that somehow lived inside him, and that he did not comprehend or control. He tried to be open to this knowledge and use it in the advantage of his clients nonetheless.

Again father came alone to the next session. He said that he did the task, but that it was not successful at all. He was very disappointed. He told me how he had prepared his slides. He had made a selection of 150 slides he wanted to show his son. This had been a very laborious and emotional process for father. When he started to show the slides, Tim was very interested to learn more about his father’s past. After 20 or 30 slides, however, he lost interest and he said to father that he wanted to watch television. This was a big blow for father. He was very disappointed. I also felt disappointed. I did not know exactly what to do next. I reflected that the hypothesis I had was useless and that I had to find a new one. I needed fresh ideas. I proposed to talk with the family again next session. Father agreed.

In this session, the hypothesis that had been useful until then proved to be no longer useful. It did not help the conversation any further. No space was created for new stories, or new ideas. Therefore the therapist took some distance again, and opened a broader perspective by inviting the family to the session.

The next session Tim was not present. Father said smiling that Tim preferred to go to his soccer training. Mother also smiled. That surprised me. Then they told me that a miracle had happened. Tim had not had any nightmares in 2 weeks.

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Father: The last time he had a nightmare was the night after I showed him some of the slides of my youth.

Then he told what happened that evening. Tim was crying in his bed and, for the first time in months, father decided to go upstairs and comfort his son. When he came to his son’s bed, the boy sobbed and said that he had dreamed that he woke up and that both his father and his mother were dead. Then father said to his son: “That’s what happened to me,” and he explained to Tim how he woke up as a 9-year-old boy to find out that his father had committed suicide. Tim cried and so did father, and they also talked. That was the last night that Tim had a nightmare.

The therapist was totally taken aback by the change that, at least in his view, was there out of the blue. This illustrates that change in families is often unpredictable by therapists (Anderson, 1997; Ausloos, 1999). The therapist does not master change: Not with theories, nor with techniques, nor with knowledge. As Lamer (1998) states: “In therapy, change does not occur from a conscious intention to apply theory as technology, but falls from life. It is what happens between theory and its practice” (p. 566, italics in the original). Still, a hypothesis sometimes gives the therapist an illusion of mastery, predictability and control. The therapist needs this illusion to survive in the chaos of the family session. However, how change develops in a family system, and why, is often beyond the therapist’s grasp. When it happens, usually it is surprising and unexpected. That is why Lamer (1998) states that “the therapist’s primary responsibility is to be humble about the workings of our craft” (p. 567, italics in the original).

The case of Tim’s nightmares also illustrates that what is called hypothesis in this context is not a smooth, streamlined theory about the functioning of Tim’s family. On the contrary, the hypotheses of the therapist in the family session are rather simple connections between elements of observations, ideas, theories, and so on. The image that is painted in a hypothesis remains sketchy. A hypothesis has some coherence and some direction, but it is not a “nice coherent, well-organized narrative, with everything in its place” (Shotter, 1993, p. 127). Such a smooth hypothesis would be dangerous, because it would disturb the balance between centripetal and centrifugal forces as it would make the therapist blind for other possibilities or other perspectives. The therapist’s inner conversation would risk becoming a monologue as all the therapist’s thoughts would be decontextualized, “and made into an orderly or systematic whole” (Shotter, 1993, p. 128). Then the therapist’s attention would be diverted away from the fact that “we are embedded in a context, and quite often our circumstances surround us with possibilities” (Shotter, 1993, p. 128). So what might appear as a weakness of a hypothesis, the quality of sketchiness of the connections between thoughts, observations, ideas, and so on, is in fact a benefit: it helps the therapist to keep an open mind toward the unique and unpredictable features of the context, and to the multiplicity of voices in the inner conversation.

CONSTRUCTIVE HYPOTHESIZING

Notwithstanding the important function of helping the therapist feel comfortable in the family therapy session and offering the therapist a sense of order and understanding, it is clear that there also are dangers connected to hypothesizing in therapy, especially considering the above mentioned ethical choice for a collaborative therapeutic relationship. If the process of hypothesizing guides the therapist’s attention and questions in the session, does not the therapist run the risk that to focus on themes that are important for him or her, but not for the family? Is not there the danger that the therapist pushes the conversation in directions that are pathologizing for the family, or for one of its members? If hypothesizing is a tool that helps the therapist select the relevant from the irrelevant, how will the therapist ever see new things that do not fit his or her hypotheses? These are important questions that mainly reflect a concern that the therapist’s illusions of power and certainty not rule the conversation. It seems advisable that hypothesizing would be informed by principles of curiosity and empowerment, instead of by principles of power and certainty (Amundson, Stewart, & Valentine, 1993). Considering the seriousness of the dangers of the use of hypotheses, it would probably be wise to make some additional recommendations to therapists concerning the hypotheses they use in the session to prevent some of the above-mentioned dangers and to ensure constructive hypothesizing.
and a collaborative therapeutic dialogue.

The therapist should always remember that a hypothesis is a construction, not a reflection of a reality. It is a supposition: tentative, limited, value laden. In the therapist’s hypotheses, deficit terminology (Gergen, 1991) is avoided. The family members are not described as sick, crazy, or bad, but as unique human beings doing the best they can to deal with the obstacles and difficulties they encounter in their lives. Problem behavior is viewed as meaningful for the system, because it signals stress in another part of the system, because it expresses feelings that can not be expressed openly, because it pushes the family to grow, because it protects family members against pain, and so on. Hypotheses have to connect sufficiently with the view of the family. There has to be some (often unspoken) congruence between the therapist’s hypotheses and the family’s ideas about what is going on in the family. Inspired by Andersen (1987), we could say that the therapist’s hypotheses have to be unusual, but not too unusual, for the family members.

Working with constructive hypotheses does not imply that the challenging aspects in the lives of the family members (e.g., pain, loss, shame, anger) should be denied or repressed. On the contrary, these challenging aspects are accepted as very real and important. In addition to this acceptance, the hypotheses express some understanding for the way these challenging aspects of life are meaningfully connected with a broader context. The so-called defensive responses of the family members, are considered rightful ways to protect themselves against threats they experience (Rober, 1999). Instead of trying to force an opening or outsmart their defenses, it is important to try to understand the good reasons the family members might have to protect themselves. The therapist should adopt an “attitude of permanent vigilance” (Maturana & Varela, 1987, p. 245) and constantly monitor his or her inner conversation, evaluating whether thoughts and ideas are constructive and respectful. If the therapist finds that his or her hypotheses are not constructive and respectful, the therapist can search in the inner conversation for more constructive ways to view the family. It is also possible for the therapist to ask the help of colleagues or supervisors. Furthermore, other kinds of questions can be posed to the family members, the answers to which can help the therapist correct hypotheses and make them more constructive.

These recommendations show that, in this view of the process of hypothesizing dialogue and ethics rather than truth come to the forefront as the first considerations of the therapist in the family session. The therapist selects hypotheses, not on the basis of their truth status (“Is my hypothesis true?”), but on the basis of both their dialogical value (“Do my hypotheses connect sufficiently with the view of the family members so as to be useful to open space for the not-yet-said?”), and as their ethical value (“Are my hypotheses constructive and respectful towards the family members?”)). This concept of constructive hypothesizing implies a radical choice for a dialogical therapeutic relationship in which the therapist is open to the feedback from the family members and in which the therapist is prepared to be critical toward his or her own biases and prejudices. It also implies that the therapist is not caught up in hubris and fantasies of mastery and control, but instead adopts a humble and generous attitude toward human existence. These ideas will be illustrated in the next case story.

CASE STORY: THE GIRL WHO DIDN’T WANT TO GO TO SCHOOL

I was working with a family, including a daughter of 7, who was referred for behavioral problems. They were a poor, multiproblem family. In the first session mother started to talk about her own painful childhood, in which she had been beaten by her parents. As a child she had felt very lonely and neglected. In the second session we were talking about the way mother and daughter got along together at home. Then mother said that her daughter never went to school.

Therapist: She never goes to school?
Mother: No, she prefers to stay at home and watch television.
I asked her if her daughter does not have to go to school? But mother replied that she did not want to fight with her about it.
When I heard this I reflected: “How irresponsible of this mother! Of course children sometimes say they do not want to go to school. Of course they prefer to watch television. But it is up to the parents to talk with them, and if necessary make them go to school.”
I started to think about ways in which I could help mother become more responsible. In my mind, immediately—seemingly spontaneously—a hypothesis was formed in which I connected mother’s “irresponsibility” with the “behavioral problems of the girl.” I reflected: “No wonder this girl has behavioral problems, with such an irresponsible mother. Mother has been neglected as a child and now, in a way, she is again neglecting her own child.” But as I listened to my own thoughts, I was struck by my being very protective toward the child and very blaming toward the mother. So I started wondering how my hypotheses could become more constructive. I did not find a way in the moment, so I decided to ask mother.

Therapist: Mother, I think I can understand a child who doesn’t like to go to school. I have more difficulty understanding a mother who accepts that and who lets her child stay at home to watch television. I would like to understand you better. Can you help me understand?

This was for mother an invitation to explain how she had tried to get her daughter to go to school, and how she had pleaded with her and explained the importance of an education. But every time the daughter said “no,” and she refused to go. The more the mother tried to make her daughter go to school, the more the daughter refused, and the more the mother felt helpless and impotent.

Mother: One day, in such fight over school, I became very angry and I hit her. She started to cry and I felt very ashamed.

Mother started to weep. I asked if she could tell me more about her shame.

Mother: I felt ashamed because I had sworn that I would never hit my child, as my parents had done to me. Since that day I decided that I would not fight with her again over going to school. Since that day she stays at home and watches television.

Mother’s story made me understand that she was not an irresponsible mother, but that she tried very hard to do a good job as a mother. She certainly did not want to repeat the mistakes her parents had made. I had no difficulty in generating a constructive hypothesis about what was happening in the family.

This example highlights how in the process of constructive hypothesizing, knowledge is secondary to the ethical aspect of the hypothesis. The therapist monitored his own thoughts in his inner conversation. He noticed his own unconstructive and disrespectful thoughts about the mother. Then he tried to find ways to think more constructively. Instead of repressing or denying his negative thoughts and his irritation about what happened in the session, he used them as a starting point for a respectful dialogue. The therapist started with expressing the negative thought (his irritation, his uneasiness) about a family member, and then he said that his negative thought clearly reflected the fact that he didn’t really understand her: “Can you help me to understand?” he added. The therapist relied on the client’s knowledgeability (Billig, 1997) as the royal road to understanding. This opened space for an important story that had not been told yet.

It could be argued that in this case story, as well as in the previous one about Tim’s nightmare, it is exactly when the therapist was able to step back from his hypothesis that change occurred. This illustrates that the usefulness of hypothesizing does not lie in holding on to hypotheses whatever the cost. On the contrary, it means that in a dialogical view, hypothesizing is essentially a process of knowing and not knowing, of holding on to and letting go of ideas and explanations, in response to the feedback from the family members. We cannot avoid having hypotheses. We operate with them all the time. But we can be vigilant, and constantly monitor the hypotheses in our inner conversation, evaluating whether they are helpful and constructive in the context of the family session.

CONCLUSION

Therapy is a complex process, about which Larner (1998) writes: “This is where the therapist stands: outside therapy while inside, and with a sense of humility and astonishment when change occurs” (p. 567). It is a process characterized by uniqueness and unpredictability. Whatever the therapist does or says in the conversation with the family, fantasies of mastery should be kept in check. Constructive hypothesizing should not be seen as a new technology that brings change in the family. On the contrary, in the process of
constructive hypothesizing the therapist’s knowing goes hand in hand with not knowing and unpredictability. In a sense, change is a sacred event that can be welcomed by the therapist, but not mastered or controlled. Change calls for silence and celebration, humility and thankfulness. As Larner (1998) wrote: “I have come to regard change in the persons and families I see as a precious and blessed event. I no longer look for a connection between our conversation and their changing. And yet a connection there may be, if things ‘fall well’ with them as with me” (p. 567).

Maybe family therapy practice can best be compared with making a voyage through some unknown country, on a strange continent. The travelers have maps, but they are not sure if they can trust these maps, neither do they know how accurately these maps represent the territory they are crossing. The travelers face a lot of uncertainty and insecurity, because on this journey unexpected things are bound to happen. Just like these travelers, the therapist does not have a lot of tools to fulfill the therapeutic mission. There is the inner conversation and the hypotheses of the therapist that are useful as maps that can guide them (Burbatti & Formenti, 1988); the hypotheses help them to find their way through the unknown territory. There also is the dialogue with fellow travelers in which the usefulness of the maps can be discussed and evaluated.

Of course, as Bateson (1979) wrote, the map is not the territory. The territory is vast and infinitely complex. A useful map, however, is a simplification; it is schematic and concise. Relevant things are highlighted, whereas unimportant things left out. Although the map is not the territory, without a map the travelers would certainly be lost.

REFERENCES


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