

**ECOSYSTEMIC PSYCHOLOGY**  
FIRST AND SECOND ORDER CYBERNETICS

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*Critically compare the epistemologies governing the first and second order cybernetic approaches in terms of the following:*

## **1. How is reality seen by each specific approach?**

### **Defining Reality**

Before attempting to describe similarities and differences around how these two approaches view reality, a look into what the word 'reality' means would be appropriate. Reality is defined as a real existence or actual being as apposed to imaginary, idealised or false. It is something that actually happens in real life and is comparable with fact (Rooney, 2001; Branford, 1987). The information sources chosen for this definition were Oxford and Encarta. From this definition one could deduce that reality is something which could be observed; something which could be quantified in a finite manner. The definition evokes the idea of reality being something that anyone at a given point in time could notice as well as that what is noticed is now some type of actuality or fact. One wonders where and how this 'reality' is perceived.

Another way of looking at reality is to see it as referring to all that which forms an integral part of what an individual believes to be real (Reber, 2001). Here we see that the idea of objectivity is replaced with the notion of personal objectivity or more correctly subjectivity. Perception and belief relates to an individual and hence from this definition the idea of reality becomes a personal reality.

### **First and second order cybernetics**

Already from the definition of reality we have somewhat of an opposing view of what reality is or could be. This difference of view point is similar to how first and second order cybernetics would define reality. From a first order cybernetic perspective one could ask what really is reality? This question would not be in line with a second order approach in that the previous question gives rise to the idea of there being a single construct or value for reality. A truth that is discoverable and obtainable that can then be used as an example that can possibly be put onto a pedestal for a group of people to view it. The idea of a finite truth and there being a real world that can be known with objective certainty is contrary to a second order perspective.

### **The challenge from second order cybernetics**

Maturana challenged the way we assume to perceive reality. His findings conclude that there would be no way to be sure of what we think we see is actually there. Maturana proposed a self-enclosed nervous system. Maturana speaks of structural coupling, which according to Hoffman (1985) is similar to skipping rope jumping with one's eyes closed. She says that it is as if we never actually "obtain" or "touch" the stimulus but rather we generate trajectories invisible to us that are mutually constrained whose connections show up on our panel. Reality is seen as a social construct. Our ideas regarding the world are observer-dependant and not necessarily matched by events and objects "out there" (Boscolo et al, 1987).

### Reality as a Multiverse

Perception is a process of construction, that is, we invent the environment in which we find our self as we perceive/construct it (Becvar & Becvar, 2006). Each person is seen as being able to create their own reality and thus each person would have a different reality from the next person based on each's unique mixture of experiences, genetics assumptions and thus perceptions. For each person, their reality is both personally true and valid. The idea of one single universe is not in agreement with

second order cybernetics, rather, persons live in a multiverse of many equally valid observer-dependent realities that has no place for objectivity and thus not even subjectivity (Becvar & Becvar, 2006). A storied reality is assumed from a second order cybernetics perspective.

### **The observer and reality**

From a first order epistemological stance, the therapist perceives reality as something that one can discover through a process of observation without being influenced by this process. The therapist thus can discover and treat problems from an outside stance in order to initiate change. Second order cybernetics sees the observer as part of the observed. Reality is self-referential with no reference to an outside environment. The system is seen as closed with in-tact boundaries where only negative feedback may be defined. There is an emphasis on internal structure and structural determinism. There is a focus on mental processes (Becvar & Becvar, 2006).

The second-order therapists acknowledge that they work with the perceptions and constructions of both their clients and themselves (Becvar & Becvar, 2006). Reality is something that can never be completely understood from another individual in an absolute truth. The therapist's observations influence what he/she sees and acknowledges that there are many alternative, yet equally valid perceptions of the same phenomenon. The therapy process is influenced by the realities of everyone involved as the process takes place in a larger societal context.

### **Conclusion**

First and second-order approaches are consistent with each other in the assumption that reality is understood as perceptually constructed or created (Becvar & Becvar, 2006). However, this reality may be explained and interpreted in first order therapy from an isolated remote position, while a second order approach is aware that it is not possible to understand another's reality without being a part of it during the process. They also both focus on context and the importance of communication. To gain an understanding of this context requires an investigation of individual perceptions and meanings as well as the overarching social system within which the relationships are included. Both have a focus on an idea of a relational context. The second order theorist differ in that they do not believe that there is any single correct or valid way to live one's life, thus reality is not a given.

## 2. How is health and pathology addressed by each approach?

### Introduction

To define pathology one would need to have a reference of normalcy. The idea of a reference is often found in first-order approaches such as in the structural family therapy approach. Here there needs to be a model of normality against which to base its assumptions of deviance. This is achieved through interviews with 'effectively' functioning families from different cultures. This acts as a reference (Minuchin, 1974). From these statements one could deduce that there is a notion of what is healthy and what is not. What is right and what is not. Second-order approaches would not agree with the idea of a reference as to what is right and what is wrong. And strictly speaking, pathology is related to context, thus health and normalcy could not be easily identified from a second-order perspective. The idea of trying to define and label relates to the concept of diagnosis, which in itself is not in keeping with a second-order perspective.

### Can family health be defined from a first order perspective?

Many first-order approaches would allow for such a definition. For example Minuchin's structural approach will be used to illustrate this:

For proper family functioning the boundaries of subsystems must be clear. They should be well defined so as to allow subsystem members to carry out their respective functions without unnecessary interference. These boundaries must however allow contact between the members of the subsystems (Minuchin, 1974). Subsystems that have clear lines of responsibility and authority drawn enable better functioning (Minuchin, 1974). Therefore, according to Minuchin (1974), the clarity of boundaries within a family can be a useful parameter when evaluating family functioning. Minuchin goes on to describe when and how difficulties or problems may arise. He talks about enmeshment, autonomy, transactional patterns, developmental considerations etc, which have all been used to describe a healthy and an unhealthy family structure and or process.

### The Site of Pathology

The family normally enters the therapy process as a response to the symptoms of one of the family members. This person is termed the "identified patient" and is often seen by the family as "having problems" or "being the problem" (Minuchin, 1974). According to systems theory, the identified patient's symptoms can be assumed to be a systems-maintaining part of the family.

The symptom manifested by the identified patient may be an expression of the family dysfunction, or as a result of the individual family member's life circumstances and has thus been maintained by the family as a whole (Minuchin, 1974). The system would then tend to reinforce the symptom.

Not only does Minuchin define pathology and normalcy, he also describes how it occurs and how to reduce it. The above is compliant with first-order approaches in that Minuchin's role is that of someone who can objectively 'see' the pathology as apart from of the family. It is as though he is analysing it from a "G-d's eye view". On the other hand his approach stresses internal structure, process and individual reality which are in keeping with second-order approaches. However he does advocate deliberate interventions to change patterns which are not in keeping with second-order approaches.

## **Can family health be defined from a second-order perspective?**

The answer that comes to the author's mind is: What then is a healthy family? And based on whose framework?

The idea of pathology is related to a framework which in turn is espoused from culture and society. A person's worldview is mirrored in their use and type of language. Becvar and Becvar (2006), define a conceptual framework as a worldview, or a set of assumptions about the world according to which similarities and/or differences are noticed. If behaviour is defined as pathology from one's conceptual framework, this framework also influences ways of dealing with the pathology and logical solutions are limited to those consistent with the framework (Becvar & Becvar, 2006). From a different frame of reference, the original pathology from the first framework may no longer be pathological anymore. Thus as Becvar and Becvar (2006) state, it is important to reiterate that the labels "healthy" and "dysfunctional" are attributions that are made consistent with one's personal values and those of the society in which one lives. In a similar way, the experience of a problem only exists relative to a given framework of reasoning.

The author is now faced with a problem as the author cannot attempt to enforce some absolute correct notion of answering this question even if it is to leave the reader with only ideas as to what might be options as this too may have a way of influencing a perception. Nevertheless, an attempt has been made.

### The idea of labels

Pathology is and consists of labels. People look for labels when they are confused, and thus it is very easy to fall in the trap of labelling behaviour. Boscolo et al (1987) wrote:

Once labelling has been accepted by the family, then all behaviours are related to the labelling ...I am always impressed by the power of labelling: "You are cooperative"; "You are good"; "You are bad". It is like being cast in a role in a play and never being able to get out of it. If you say "I get along with my son, we have fun together," that's relational. But if you say "My daughter is intelligent," you use words to kill the relationship. To unstick that kind of system, you must bring in a process that helps people get away from labels – not only negative ones, but positive ones too (p.44).

Second-order cybernetics would say that diagnosis exists only in the eye of the observer. Furthermore, diagnoses are seen as attributing causality and hence blame which acts to reinforce the problem they are meant to explain. The second order approach says a problem is only valid if the client him/herself sees it as such. Thus, there is an emphasis on the way the client defines it. How the client communicates about his/her problem is more important than the problem itself.

### The problem creates the system

The old epistemology implies that the system creates the problem. This is in contrast to the new epistemology which implies the problem creates the system. The problem, according to Hoffman (1985), is whatever the original distress consisted of added to whatever the distress on its journey through the world has managed to attract to itself. The problem is seen as the system of meaning created by the distress and the therapy system who is contributing to that meaning system. This also includes the therapist as soon as the client enters the room (Hoffman, 1985).

The old idea of treating a mental symptom was based on the assumption that a part of the body required treatment. The pathology existed "in" the organism or individual or family. This is not in keeping with second-order cybernetics as in this epistemology the problems exists "in" the heads or perceptual apparatus of everyone who has a part of naming it. The idea of a person who is sick who goes to see someone who

can “fix” him/her is in keeping with first order cybernetics where there is a dichotomy between client and therapist.

### **What then is a healthy system from a second order perspective?**

A healthy system uses the available energy in a coherent manner and thus the distribution of energy is effective while an unhealthy system may devote too much energy to a single aspect at the expense of other aspects (Becvar & Becvar, 2006). Added to this, the idea of healthy or not healthy is related to how the family view themselves. According to Becvar and Becvar (2006), the main concern of the therapist is how families do best what it is they want to do rather than with what they are doing. Health is defined as the family’s success in functioning to achieve its own goals (Becvar & Becvar, 2006). These goals and this structure is determined by the family itself and not by the therapist.

Becvar and Becvar (2006) state that a happy family is one in which happy things happen. Families who choose to devote their time and energy to positive processes have less energy available for negative processes and vice versa. Positive processes have a revitalising effect while negative processes weigh down the system (Becvar & Becvar, 2006).

### **Conclusion**

At the level of simple cybernetics we can observe a system and decide how healthy or pathological it is. Second-order cybernetics does not accept any definition that implies good or bad with respect to the system. A system responds to various perturbances in a manner that is consistent with its structure, therefore, all systems do what they do and cannot be seen as pathological unless we call it that (Becvar & Becvar, 2006). Therefore,

second order cybernetics suggests that there are no problems in the cosmos. It is a total, unified whole in which everything fits, is coherent and makes sense. The problems we treat are the problems of a given frame of reference or world view (p.358)

Thus in the second order approach nothing is seen as being negative in itself; but it becomes negative when the listener perceives it as negative.

The extract below is exactly the opposite of what second order cybernetics attempts to manifest:

You [the professional] are always checking me out...checking me out, to see if I knew what you knew rather than find a way to talk with me. You would ask, ‘Is this an ashtray?’ to see if I knew or not. It was as if you knew and wanted to see if I could...that only made me more frightened, more panicked. If you could have talked with the ‘me’ that knew how frightened I was... (Anderson & Goolishian, 1992, p.25).

### **3. How does each specific approach deal with therapy? What is the notion of change involved in each approach?**

#### **Introduction**

The first order approach to therapy emphasises the degree of openness or closedness in relation to the boundaries, that is, to what degree is information able to permeate in and out of the system. The relationship between stability and change is defined. The system's tendency to move toward or away from order is an important aspect. Both first and second order approaches see change as requiring a change in context. The second order approach highlights meaning and understanding, which is a matter of negotiation that takes place between the participants of therapy. Through language and conversation, the participants conceptualise memories, perceptions and histories and what these signify. In line with second-order cybernetics, the Milan team believe that there can be no 'instructive interaction,' only a perturbation of a system that will then react in terms of its own structure (Boscolo, Cecchin, Hoffman, & Penn, 1987). An emphasis on setting a context for change, not specifying a change is preferred in second order approaches.

#### **CHANGE**

##### A theory of change

Watzlawick, Weakland, and Fisch (1974) distinguish between first and second order change. Change that occurs within the system and is consistent with the rules of the system is referred to as first-order change. When the rules of the system and hence the system itself is changed, it is termed second-order change.

Second-order change seems to be illogical or paradoxical when considered from its current framework with its current rules (Becvar & Becvar, 2006). If the rules are changed, the way we view the problem changes and hence our perception is changed. New behavioural alternatives become possible in the process (Becvar & Becvar, 2006).

##### **An example of how change is facilitated in a first-order approach**

The use of Minuchin's structural approach is to follow:

Therapy is based on changing the organisation of the family (Minuchin, 1974). Minuchin states that when the structure of the family is transformed, the relative positions of its members also changes accordingly, resulting in a change for each individual (1974). Change in the family structure can have an effect on the behaviour and the internal psychic process of the members within the system (Minuchin, 1974). By changing the immediate context of the family members in a way that changes their respective positions, a shift in experience can be initiated (Minuchin, 1974). The individual's subjective experience can be changed when the relationships between the members or a member and another has been changed. Change affects the member's new circumstances and new perspective of each other and themselves in their environment.

##### Feedback as a Change Agent

Although value judgements are not made regarding feedback, there is a difference between whether the feedback initiates a change to be accepted by the system. In such a case the feedback is termed positive while negative feedback resembles a system that maintains the status quo. Both feedbacks may evoke good or bad outcomes. Context is the backdrop as to whether feedback can be seen as having a good element or a bad aspect.

## **The idea of change in a second order approach**

### Perturber versus Change Agent

Second order change is facilitated as the therapist and client co-create a new context in which old, problem-saturated constructs are deconstructed and new, solution-focused stories are authored by client and therapist through mutual interaction and feedback. This occurs in the process of respectful dialogue in which situations may be perceived differently. Second order therapists are aware that one does not change systems or treat families. Rather, one changes his/her behaviour, examines the impact of this new behaviour in terms of reactions to it, and then reacts to reactions in an ongoing modification process. If the interaction thus described is characterised by a change in the system, we may say that feedback has been established and a change in context has occurred. The strategy is to create a context in which the desired outcome – a change in behaviour – is a logical response.

A change in language exhibits a change in the experience; for reality can only be experienced, and the “reality” experienced is intermeshed in the thoughts of the structure of understanding (Becvar & Becvar, 2006).

Second order therapists are aware that one doesn't strictly speaking influence people, one only influences the context, and thus the only part of which you can control is yourself (Hoffman, 1985).

Method is replaced with stance. Second order approaches make use of the environment as a change agent. The therapist's openness creates an environment for change to take place (Griffith & Griffith, 1992).

Therapy is seen as a linguistic event that takes place in a “therapeutic conversation”. This type of conversation is where a mutual search and exploration takes place. An exchange of ideas in a context where new meanings are continuously manifesting towards the ‘dis-solving’ of problems (Anderson & Goolishian, 1992). Change occurs with the creation of new narrations of current meanings. Change is synonymous with the genesis of a greater context for new behaviour. New meanings derive from a different narrative of a previously held meaning. The possibilities of the organism's structure is related to the environmental constraints but the organism can do or become whatever its structure allows it to do or be provided that this is not disallowed by the environment.

During the therapy process, the therapist is continually readjusting his/her understanding of the client and thus is in a process of continuous change. The role of the therapist is to try to understand the constantly changing world of the client. No attempt to analyze or dominate the client with psychological doctrine takes place. The therapist learns from the expertise of the client and is led by the phenomena itself as it manifests itself.

Successful therapy is concluded when a new narrative has a liberating effect with a feeling of freedom felt.

## 4. What Is The Role And Function of the Therapist in Each Specific Approach?

### Introduction

First order therapists describe what is happening inside the system from an outside position. They assess and attempt to change behaviour relative to their background which is related to normative standards and societal approvals. Problems are seen as being “out there” in a real, knowable reality (Becvar & Becvar, 2006). The therapist is seen as the expert (e.g., coach, choreographer, director). He/She sets the goals as mandated by his/her theory and treats the “real” problem, which is the underlying structural flow or faulty processes built into the system. In contrast to this, the second order therapist is part of that which is to be observed and hence may only describe the combination of observing systems (Becvar & Becvar, 2006). Therapy is seen as a collaborative process between therapist and the client system. The therapist participates with the client in deconstructing the universal truth story the client brings to therapy and collaborates with the client in constructing a new story that solves/dissolves problems defined by the presenting story. Of major concern is the context to which the client’s problem exist as well as the meaning of the problem as described by both the client and the therapist takes place. The focus is more on the client than on some preconception of what is really going on in the client system. The goal is not to impose some normative way (according to the theory of the therapist).

### An example of a first order approach to therapy

*Using the structural approach to illustrate first-order therapy:*

#### The Scope of the Therapist

Structural therapy relies on action in that modifications to the present context are undertaken. The therapist uses himself as a tool to transform the family system. The positions of the family members are often changed which then changes their subjective view of the family. The therapist’s place in the family is that of one who is to modify and repair rather than that of an educator (Minuchin, 1974). The therapist explores the individual’s interactions within significant life contexts. An observation of the relationships of the family members to each other is common (Minuchin, 1974). The therapist has the ability to see first hand the relationships between the members rather than relying on the individual reports given in isolation only. The therapist is not restricted to the family interaction as shown by one family member, but can experience the way in which the family interact with each other. The therapist can then develop a transactional theory which he/she uses to explain the interactions to which he/she has observed (Minuchin, 1974). A therapist’s behaviour becomes part of the context of the family system, thus the therapist and the family join to form a new, therapeutic system which now sets the context for the behaviour of its members (Minuchin, 1974). The goal of family therapy is for the therapist to join the family with the aim of changing the family organisation with the final outcome of a change to the individual members experiences (Minuchin, 1974). Minuchin states(1974):

A therapist often functions as a boundary maker, clarifying diffuse boundaries and opening inappropriately rigid boundaries. His assessment of family subsystems and boundary functioning provides a rapid diagnostic picture of the family, which orients his/her therapeutic interventions ... The therapist’s task is to help the subsystem negotiate with and accommodate to each other ... At times, the therapist must act as a translator, interpreting the children’s world to the parents or vice versa. He may also have to negotiate clear but crossable boundaries with the extrafamilial ... In pathological families, the therapist needs to become an actor in the family drama, entering into transitional

coalitions in order to skew the system and develop a different level of homeostasis (p56-60).

The therapist listens to the individual realities of the members based on their experiences in the family. The therapist is aware of the way in which the members relate to each other and to him/her which then is the basis for his structural diagnosis. The therapist observes and tries to pinpoint transactional patterns and boundaries. He makes hypotheses about whether the patterns are functional or pathological, all while deriving a family map (Minuchin, 1974).

#### Probing within the therapeutic system

The therapist may impose different tasks to the family. The therapist attempts to probe the dysfunctional structure with the aim of locating areas of possible flexibility and change. Underlying structural alternatives hopefully present themselves. The therapist's function is to help the identified patient and the family by facilitating the transformation of the family system. The therapist in his position of leadership in the family develops therapeutic goals based on his/her initial assessment of the family. He/she intervenes in ways that facilitate the transformation of the family system in the direction of his/her chosen goals. The therapist's focus should be to enhance the operation and healing of the family members. The responsibility for reaching the therapeutic goals lies with the therapist (Minuchin, 1974).

#### Disequilibrium in Transformation

In order to transform the family system, the therapist must intervene in the family system in a way so as to imbalance it (Minuchin, 1974). The family's dependence on the therapist is integral in the transforming process. When the therapist unbalances the system by joining with one member, the other members experience stress. Their responses may be to insist on maintaining the status quo that they were originally comfortable with. The therapist's role is to counter this by insisting that the family members move in the direction of the therapeutic goals while enduring the uncertainties of the transitional period (Minuchin, 1974). The family therapist challenges the family member's perceptions of reality. The therapist challenges each member's certainty of the validity of his/her experience in a supportive way with the goal of broadening each member's perception of their experience (Minuchin, 1974).

#### **An example of a second order approach to therapy**

The reality of the therapist rests on his/her ideas and therapeutic framework. Understanding and rapport between client and therapist reaches a summit when reality is negotiated that highlights resources and choices for solutions. These solutions are often discovered by the family members themselves. The therapy environment should be seen as a place where all involved reside together. The emotional posture of the therapist is linked to his/her understanding of his/her own reality, thus the therapist's ideas and perceptions relate to the *negotiated reality* between therapist and family. The therapist needs to be aware of their therapeutic framework as this changes the working reality between client and therapist. The conditions required for a healthy interpersonal context includes a readiness on the part of the therapist to speak and listen in a manner that invites dialogue. Suggestions and interventions are often offered in a tentative, suggestive manner that may be helpful for the client in achieving his/her goals.

### Emotional Posture

An awareness of the influence of bodily states for conversation is important in many second-order approaches. Bodily states that show care, trust, sharing and active listening promote reflection as a process of meaning reconstruction (Griffith & Griffith, 1992). The therapist should be aware of the bodily states of the family members as well as his/her own state, as having an influence on the dialogue. An awareness of facial expression, posture, breathing, tone of voice, eye-contact and direction of gaze help to improve one's understanding of what is manifesting in the therapy. An awareness of incongruent bodily states helps to understand the relationship between the verbal and analogue information. Therapeutic dialogue must make way for alternative solutions, new meanings, reconstructions and reinterpretations. The therapeutic atmosphere is co-created. Curiosity, openness and respect is manifested in a joint manner by the people present but it is the responsibility of the therapist to enter the therapy room with an emotional posture that invites these factors to evolve (Griffith & Griffith, 1992).

### A not-knowing stance

There is a responsibility on the therapist for creating an atmosphere of curiosity, openness and respect. Curiosity manifests itself in an environment of seeking an understanding. The therapist takes the stance of realising that he/she does not have exact answers as to how the behaviours of family members need to be. An awareness of one's own ego and arrogance in that the therapist cannot know for sure how to solve the problem. Curiosity is lost by a therapist who is a "know it all". The therapist is seen as a conversational architect who has extensive experience in the art of creating a domain for and facilitating a dialogical conversation (Anderson & Goolishian, 1992). The therapist uses therapeutic questions as his/her primary tool to facilitate the conversational domain and the process of dialogue. The therapist's conversational framework is that of a 'not knowing'. He/she is not looking for specific answers as he/she has no preconceived ideas or diagnostic definitions that require a method for therapy.

The skill of the therapist rests on his/her ability to participate in the re-creation of new meanings during the therapy process while always being aware that our 'self' as always changing (Anderson & Goolishian, 1992). The dialogical process is a continuous process where meaning is continuously manifested. The therapist is not seen as the idea generator or meaning giver but rather ideas and meanings emerge from the dialogue between the therapist and client in co-owned, co-created partnership. The therapist is thus included in the meaning of the conversation.

### Making the Expert Disappear

The second-order approach calls into question the expert status of the professional. Questions or comments that begin with phrases like; 'could it be that?' or 'what if?' immolate or reduces the professional persona and enhances participation and invention (Hoffman, 1992). There is a reduced status of the therapist. Hoffman (1992) gives an example of this as follows:

the significance of her silence for how her respondent comes to tell her story in her own way, noting that at many points, for example, when the respondent paused, she remained silent when she might have entered the stream of speech (p.19)

### The Milan Approach

The therapy environment is seen as a research operation undertaken by both therapist and family (Boscolo et al, 1987). The idea of neutrality as advocated by the Milan group pertains to the seemingly neutral stance of the therapist. The Milan's idea of "neutrality" evolved from Bateson's premise that all parts of a given system

must, if the system is seen systematically, be given equal weight (Boscolo et al, 1987). It relates to the multi-positional stance of the therapist. If the therapist achieves neutrality during the therapeutic process, no one in the family would or should be able to say that the therapist has taken anyone's side over another's. This therefore exempts the idea of taking moral stance since this would mean taking one's side (Boscolo et al, 1987). Neutrality is manifested by the circular questioning which allows the therapist to move between the dialogues of the different members without getting stuck to one view or route. The therapist is an active contributor as is everyone else in the treatment unit which together creates a meaning system.

### **Conclusion**

First order approaches seek to make objective observations to discover facts. They use these facts to form a theory or hypothesis to explain the facts. A prediction from this theory is made and tested by making another isolated objective observation.

The second order approach prefers an "observing system" stance with the inclusion of the therapist's own context. A collaborative rather than hierarchical structure is initiated in a non-pejorative, non-judgemental manner. A "circular" assessment of the problem is attempted with a reduced emphasis on instrumentality.

## **5 Which critical ethical concerns could be raised about each specific perspective? What do you enjoy about each approach? What are your concerns?**

### **Ethical risks associated with first order approaches**

When dealing with a family there is a risk of not taking into account the developmental process of all possible family subsystems. A therapist may join a subsystem in order to see how the system as a whole responds and is sometimes an essential part of the diagnostic process. Therefore, there is a risk of joining and supporting only one subsystem. Maintaining one's position in a way that solidifies a dysfunctional organisation is an act of blindness (Minuchin, 1974).

The ideas of disequilibrium in transformation may be unethical. In order to transform the family system, the therapist must intervene in the family system in a way so as to imbalance it (Minuchin, 1974). Transformation evokes the idea that the family needs to transform which in turn means they have been judged by the therapist. The therapist has used his/her own values against which to base his/her transformation tactics. Thus, it is as though the therapist knows what's best for the family. This is not in keeping with a second-order approach where the therapist does not know what is best. Furthermore, the transformation process relies on the family's dependence on the therapist. The therapist deliberately induces stress into the system. If the therapist does not know what he/she is doing he/she can instigate even bigger problems in the family. The therapist should monitor the effect of therapy on the life circumstances on the family and be ready to offer support.

First order approaches are known for their categorisation of healthy and unhealthy. It is necessary to avoid pathologising the family by use of labels. First order approaches run the risk of assuming that they have access to the Truth. They also may initiate a treatment plan without an awareness of the ecology of which the symptoms are related to the system and to how the supposed cure may manifest in the system afterwards. Thus the therapist needs to consider carefully the nature of an intervention relative to the assumed good it can provide and whether it is potentially constructive or destructive.

The first order approaches may need to consider the possibility that their definition of health may be too idealised to be attainable by most couples and families. We also need to seek whether our approach is functional for a particular family in a given cultural context and whether our theory of effective family process is favourable for this family.

### **An Ethic of Participation (Second-Order)**

If it were at all possible to co-create the therapy process thus allowing for an equal distribution of power. This idea tries to reduce some of the ethical problems that may arise in first-order methods. Here an ethic of participation is evoked and is in compliance with second order approaches. Participation reduces the status of the therapist. There are dangers of professionalism in that mental health professionals have an elevated status, Hoffman (1992), states:

In a free society, women as well as men must have access to the thinking of the persons they consult in order to prevent 'professionals disguised as experts' from making their choices for them. (p.23).

Control has been used in first order approaches while in a second order approach the therapist is aware that one cannot actually control the client and it would be unethical to even think along those lines.

No one has the final word in the therapy process. I view this as a critical statement. This idea creates more room for the client to take responsibility for his/her life. Participation rather than a search for 'the cause' or 'the truth' occurs in a second order approach which I would find more ethical.

### **Ethics and Second Order Cybernetics**

Diagnosis and labelling should not find themselves here in the second order domain. The problem arises with medical aids who seek a diagnosis as a prerequisite for payment. The second order therapist needs to find a way to negotiate this terrain possibly by explaining this to the client and deciding what action to take together.

Second order approaches rely heavily on language as a means of therapy. These practitioners need to be aware of the choice of words as well as the use of gender stereotypes. Awareness as to how language may continue to be experienced as oppressive by virtue both of what we say and what we do not say.

Neutrality is seen as a favourable stance in the therapy process. If the therapist achieves neutrality during the therapeutic process, no one in the family would or should be able to say that the therapist has taken anyone's side over another's. This therefore exempts the idea of taking moral stance since this would mean taking one's side (Boscolo et al, 1987). Neutrality is manifested by the circular questioning which allows the therapist to move between the dialogues of the different members without getting stuck to one view or route. There is recognition of the multiple ways in which the same situation may be perceived and acknowledgment that no one has access to the Truth.

### **Criticism of the Second-Order Approach**

Second order approaches tend to advocate the 'no hidden agenda stance'. Becvar and Becvar (2006), state that:

Although being honest about one's intention of having no hidden agendas may perhaps represent a sincere attempt to avoid manipulating the other, such honesty is still an attempt to influence, in that a relationship will be defined in which the rule is: no hidden agendas. And that, of course, is also a hidden agenda! To explicitly acknowledge one's purpose or hidden agenda only reveals a higher-order, hidden agenda. Indeed, there are no relationships devoid of hidden agendas, and there are no relationships devoid of manipulation (p.207).

Golann (as cited in Becvar & Becvar, 2006) talks of unconscious persuasion. He says that unconscious persuasion may be seen as even more ethically offensive than the explicit strategic approach as it is potentially dishonest and tends to create an even greater power hierarchy in the therapist's favour. Thus, Golann would feel that second order approaches are just as seductive as other therapies that advocate similar ideas of respect, non-manipulation, non-directiveness etc.

### **Questions that may enhance ethical conduct**

Becvar and Becvar (2006), highlight some questions that relate to second-order cybernetics. I found these questions in keeping with an awareness of ethical issues for both first and second order approaches. If the therapist could be aware of these questions then it would be unlikely that he/she would consciously create ethical problems in therapy.

The following questions have been extracted from chapter 13 of Becvar and Becvar (2006):

1. How can I have recourse to contextual family therapy in such a way that I avoid pathologising my clients?
2. I wonder how the client system would define health and normalcy.
3. I wonder what impact I have on the stories my clients are telling me.
4. I wonder what I might see and understand differently if I told myself a different story.
5. Do my pre-existing hypotheses about various kinds of families allow me truly to get to know this family from an anthropological stance?
6. I wonder how I can express myself in a way other than by intensity and still be heard.
7. How can I join the family and assume leadership in such a way that I also validate the expertise of all its members
8. I wonder what influences I am having on the patterns I am observing.
9. How can I include myself in the observations I am making?
10. I wonder how this family might behave differently if working with another therapist
11. I wonder what knowledge on the part of the clients, about themselves and their system is going unacknowledged as I assess their patterns of interaction.
12. Is my focus on pragmatics sensitive enough to what family members may be feeling?
13. I wonder what reality I am participating in creating as I operate from this approach.
14. I wonder how the family would define progress.
15. I wonder how my prescriptions can acknowledge the uniqueness of each client.
16. I wonder how I can remember to see influence as a mutual process in which all participate.
17. How can I use my understanding of schemas to facilitate awareness of the degree to which we participate in creating our realities?
18. Can I expand my view to consider larger issues and factors that may be influencing what is going on with the client?
19. I wonder if I can acknowledge that my theory is just one of many stories and does not necessarily describe the way things really are.
20. Am I responding to what the client has just said or to what the comment meant to me?
21. I wonder how I can ask "presupposing change" questions that validate my client's current experience of reality.
22. I wonder if there are times when encouraging clients to understand reality from a narrative perspective might not be appropriate.
23. If I allow the conversation to go where the client directs it, am I serving the client's best interest?
24. I wonder if I can remain cognizant of the power that accrues to me by virtue of my claim not to be an expert.

## **6. In keeping with a both-and, rather than an either-or position formulate ideas around how the first and second order cybernetic approaches can be integrated in a useful and complementary way.**

### **Introduction**

The second-order approach seeks to act as a moderator of the first order stance. It questions the 'facts' that the therapist believes to be real and leaves him/her in a world of personal values and beliefs. The two approaches seem to be complementary to each other. Just like how individual therapy is contrasted with family/systemic therapy so too is first and second order approaches contrasted with each other. However, during family therapy the therapist needs to be aware of the individual and his/her individual developmental needs, so too does the first order therapist need to be aware that there may be an alternative thought pattern which can account for a different viewpoint of equal validity.

Becvar and Becvar (2006) talk of the therapist wearing different hats. How is it possible for someone to live their life according to second order principles in a Westernised positivistic society? The answer lies in the hats. Unfortunately or fortunately we can change roles to suit different contexts, the key here is in the awareness of alternatives. One becomes aware that they can change their roles or even merge these roles and thus first and second order approaches become a dimensional quantity that lie on the same plane. An awareness of their polarity allows for their integration, that is, just like how the sadist is defined in terms of the masochist and require each other to complete the definition, first and second order cybernetics define each other.

### **Practical Issues**

Second order approaches highlight the therapist's own behaviour in the therapy process. The language, posture, attitude and values that the therapist uses are all important in the therapy process. In many second order approaches a focus on the stance of the therapist is noted while first order approaches do not account for this in the same degree. An awareness of the influence of bodily states for conversation is important. Bodily states that show care, trust, sharing and active listening promote reflection as a process of meaning reconstruction (Griffith & Griffith, 1992). The therapist should be aware of the bodily states of the family members as well as his/her own state, as having an influence on the dialogue. An awareness of facial expression, posture, breathing, tone of voice, eye-contact and direction of gaze help to improve one's understanding of what is manifesting in the therapy. The second order approach therefore adds to the first order in this area.

First order cybernetics does not adequately address the relationship that connects the therapist or observer to the client or observed person. The therapeutic atmosphere is co-created. Curiosity, openness and respect is manifested in a joint manner by the people present but it is the responsibility of the therapist to enter the therapy room with an emotional posture that invites these factors to evolve (Griffith & Griffith, 1992).

### **Conclusion**

Respect is seen as central to the second order approach where the therapist is aware of how his/her own behaviour may perturb the client. I wonder what would have happened if second order approaches were not incorporated into psychology practice. Could it be that first order approaches were getting out of hand? An

approach that defines reality in terms of its own framework, pathology is differentiated from normalcy, right from wrong, leads me to believe that the future of first order approaches may be seen as a canvas of black on the left and white on the right. When I look around my natural world I see integration. I do not see finite lines, exact sequences, and polar opposites. In fact I only see that in the man made world where buildings, cars, medical tests and engineering exist. In my natural world there exists enmeshment, broken boundaries and patterns that have no explanation other than of itself by itself. However, I would not be able to see a boundary, an enmeshment or understand an explanation unless I lived in a world where these things have been punctuated in a first order society.

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