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Promiscuity in the practice of family therapy[1]

Sheila McNamee[a]

Family therapy has continually confronted choices between polarized positions, each one taken up with zeal because it solved an old dilemma but eventually encountering its own limitations. In this article I suggest that we have evolved to a point where, instead of deciding which is better, we can focus on how to use theories, models and techniques as fluid and flexible resources for action in the therapeutic conversation. Doing so focuses our attention on how we can move in and out of various positions, including those that simplify issues and those that embrace complexity. In addition, our attention is drawn to the ways in which we can make choices between following a model as opposed to engaging in spontaneous dialogue. This promiscuous stance can help trainers and therapists answer questions concerning how we make decisions in therapy. Such promiscuity also positions us to confront our images and expectations of what it means to be a professional.

In this article I would like to propose what I consider to be a more promiscuous attitude for family therapy in an attempt to generate inclusiveness in our theory and practice. I am purposively using the term *promiscuous* here to underscore the ease with which a dominant discourse can eclipse a richly descriptive term and render it one-dimensional. In the present case, *promiscuous* simply refers to the act of mixing up. However, culturally, we have come to understand *promiscuous* as associated with immoral sexuality, seediness and unseemliness. By electing to use such a morally charged term in its original form (i.e. in reference to mixing), I hope to symbolically summarize my argument: dialogue requires us to be present in the moment, thereby opening up the space for the generative use of a wide array of methods and models in family therapy.

The theme of promiscuity resonates with the dialogic emphasis that has been articulated within many strands of family therapy

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[a] Professor of Communication, Department of Communication, University of New Hampshire, Durham, New Hampshire 03824, USA.

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(cf. Hoffman, 1998; Pocock, 1995; Seikkula *et al.*, 2003). As Sampson (1993) puts it, dialogism reminds us that '*the most important thing about people is not what is contained within them, but what transpires between them*' (p. 20, emphasis in original). When our concerns are with what people are *doing* together, the methods and models we use become less important than working together to generate possible futures. Such a refocusing as this has significant implications for our clinical work as therapists, for training others to be family therapists, and for evaluation of our work.

My main goal in this article is to propose some clarity about therapy as a dialogue (i.e. as a *process* of social construction) and in so doing, to invite the multiple voices of family therapy into the conversation as well as into our practice.[2] Let me begin by speaking directly to the issues of promiscuity and the theme of building inclusiveness within the theory and practice of family therapy.

An invitation to promiscuity

The term 'promiscuous' is derived from the French, *miscere*, which means to mix up. Thinking of this term in relation to the field of family therapy, I am immediately reminded of Cecchin's notion of irreverence (Cecchin *et al.*, 1992) and the more general, revolutionary spirit of the field as captured in Lynn Hoffman's *Family Therapy: An Intimate History* (2002). Promiscuity suggests the interface of the old and new; the use of familiar forms of action in new ways. Promiscuity might well be described as *intellectual poaching* to the extent that we might employ accepted ideas and techniques in new ways, therefore 'borrowing' them from their original context.

This sort of promiscuous activity is an apparent contradiction of our cultural ideas of professionalism. To be a competent professional, we typically expect one to be well trained in a particular model and effective in the application of that model. Consistency is admired. There is also a sense of remaining 'true' to an original form. In this respect, to be a professional might be related to clinical practice that falls well within a specific theoretical model in such a manner that there is visible respect for its authorship. We could draw a parallel to

[2] When I use the term *social construction*, I am referring to a broad array of orientations to the study of human interchange that centre on the meaning-making process. Central to this understanding is that meaning is a relational achievement, situated within a present moment *and* a cultural/historical tradition, and therefore requires a focus on what people *do together*. The emphasis within social construction is therefore dialogic.

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classical practices of music production where remaining close or 'true' to the composer's interpretation is valued. This practice, of course, is contrasted to contemporary forms of music production where 'sampling' allows one to mix a wide variety of artists, styles and formats. Sampling, then, stands as an illustration of the promiscuous stance.

Our love affair with consistency and its associated practices of *discovering* essential aspects of phenomena as well as *predicting* future states of such phenomena comes from the tradition wherein we value science over all other forms of enquiry. Science, itself, is not the devil in this story. Rather, our intrigue with science has generated a culture of scientism (Haack, 1997) where science is viewed as the absolute and only justifiable access to the truth. The *Oxford English Dictionary* defines scientism as 'a term applied (freq. in a derogatory manner) to a belief in the omnipotence of scientific knowledge and techniques; also to the view that the methods of study appropriate to physical science can replace those used in other fields such as philosophy and, esp., human behaviour and the social sciences.' Assuming, no matter what, that science will inform us about everything is a far cry from being scientific or valuing scientific method. In the field of family therapy, where our concern is clearly placed on helping families find generative ways of living together, the unquestioned acceptance that scientific methods will tell us which theory or model is the *right* one to use is more than limiting. As Larner (2004) puts it, 'To be scientific is to maintain an investigative curiosity about how and why therapy works and to accept that science may never be enough to explain the process' (p. 29). A dialogic emphasis (as opposed to scientism) generates the sort of promiscuity (and curiosity) that yields effective therapy. How is a dialogic stance different from the professional stances that emanate from scientism? To address this question requires a brief discussion of the different ways in which theorists and practitioners understand language.

Disparate views of language

It is important to remind ourselves of the philosophical distinctions introduced when we move from the assumption that language describes the *way things are* (thus, a therapeutic model, for example, can be *right* or *wrong*) to the assumption that language, seen as our embodied activities with each other, creates the ways in which we come to know and talk about our worlds (thus, a therapeutic model is more or less useful in inviting transformation). Another way to capture this distinction is to recognize that, for many, language is a

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system (of symbols and/or signs) that we use to represent our world (a view that maintains the Cartesian subject–object distinction). For others, language is an *activity* where participants jointly construct their worlds. This latter view is what Stewart (1996) labels a 'radical rethinking of the nature of language' and is articulated by a host of scholars including Rorty (1979), Bernstein (1985), Wittgenstein (1953) and Heidegger (1971). Their focus can be considered *social*. To them (and those articulating a dialogic emphasis in family therapy), language is primarily an engaged activity, not a tool we use to talk *about* the world while remaining unrelated to it.[3] There is an important implication of this distinction and this implication is significant for us if we are to move towards a more promiscuous stance in family therapy. When we view language as a system of representation, we are invited into persuasive debate with others whenever difference occurs. It is one person's truth over another's and, if language represents reality, through careful debate and deliberation, the *real* truth should be determinable. In contrast, when we view language as an activity in which we engage with others to create our realities, we are invited into dialogue *together*.

One of the by-products of conceptualizing language as a system we use to represent or picture the world is that it reduces our dialogue, our conversation, our activities with each other to a technique. Specifically, if language is a system of symbols we use to represent the world (the mind, the essential features of objects, experiences and so forth), then our task in any social interchange is to develop ways of speaking and acting that do so *appropriately*. The by-product of this is that participants in relationships attempt to persuade each other by using language in 'accurate' ways (according to them). They do so as if a specific material reality were available (although often hidden behind appearances) prior to their use of language to represent it. This form of persuasive discourse, which we try to justify by an appeal to a prior reality, permeates our institutions, including the institution of family therapy. The difficulty is that this view raises the question of what reality it is that might underlie appearances. Here opinions differ. While all would agree that accurate or truthful representations must be rationally or logically formulated, the question is *which* or *whose* logic or rationality is appropriated.

I think much of the difficulty in having meaningful dialogue among competing theories and models is an outgrowth of scientism – a

[3] For an excellent discussion of these issues see Stewart, 1996.

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privileging of one form of discourse over another. Dialogue and its concomitant stance of promiscuity is not an attempt to dominate the discursive terrain. We are simply interested in asking what happens, what opportunities and constraints emerge, if we open the conversation to other ways of understanding. We do so not as a combative act designed to illuminate the flaws of a given theory or model; nor are we attempting to avoid making compelling and persuasive arguments in favour of one theory over another. The attempt is simply to locate the 'evidence' for any given model within a relationship, within a situated conversational process.

An invitation to a promiscuous stance is not only interesting in the light of this discussion on language but comes on the heals of current research exploring the effectiveness of therapy. Miller and Duncan (2000) describe any therapeutic approach (model/theory) as having little to do with the outcome of therapy. They state, 'in terms of outcome it simply doesn't matter whether one exclusively practices cognitive-behavioral, psychodynamic, psychopharmacology, or… solution-focused therapy' (p. 23). I understand this description as inviting us to focus more on the ways in which different theories and models can be employed as generative discursive resources in our work with clients. The shift is away from using a theory or model because it is correct and towards a promiscuous stance of using multiple theories and models because they resonate with particular clients in particular, situated moments.

Let me offer a visual image of the difference I am introducing with the provocative theme of promiscuity. If we were to embody the cultural expectations of consistency and the opposition promiscuity invites in the form of art, we might look at the distinctions between Rembrandt's and Picasso's artistic styles. Rembrandt is noted for his ability to make images in his paintings appear lifelike. For example, in the famous painting, *The Feast of Belshazzar*, the gold and the jewels are rendered as *real*. Similarly, *The Syndics of the Drapers' Guild* is also a painting recognized as achieving an appearance of the real and the natural. This ability to render objects as real can be associated with competency to depict the world as it really is. There appears to be no confusion between art and life. In contrast, Picasso's work is better described as abstract – not picturing reality *as it is*. Picasso mixes art and life, objects, shapes and colours in ways that are novel. Where Rembrandt's art is described as representing reality, Picasso's is seen as a form of reality distortion – a deliberate lack of representational qualities. Gregory Bateson captures the promiscuity of Picasso's style:

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> Somebody was saying to Picasso that he ought to make pictures of things the way they are – objective pictures. He mumbled he wasn't quite sure what that would be. The person who was bullying him produced a photograph of his wife from his wallet and said, 'There, you see, that is a picture of how she really is.' Picasso looked at it and said, 'She is rather small isn't she? And flat?'
>
> (quoted in Keeney, 1983)

And, on another occasion, when addressing a complaint that his portrait of Gertrude Stein did not look like her, Picasso replied, 'Never mind, it will.'

I imagine the conversation that Rembrandt and Picasso might have about their different interpretations of the world as similar to these two interchanges of Picasso's. I wonder how these differences between *real* (objective, pure) and *created* (not authentic due to its *mixed* nature, its promiscuity) can be generative in our own practice as family therapists. Is it possible, I wonder, to coordinate professional purity with promiscuity in the practice of family therapy? How might we move beyond the conflict presented by these two incommensurate modes? In therapy, as in art, we move between those who *know how things really are* and those who are interested in *participating in the unfolding process of how things might come to be*.

It is in this vein that I would like to talk about transformative dialogue. Specifically, transformative dialogue explores how we might move beyond incompatibility and find generative ways of working between, among and within various models of family therapy. This requires valuing each theory and model in its own (pure) terms and granting it the potential for local 'truth' status in a situated moment. It is within the theme of transformative dialogue that I find a useful elaboration of social constructionist discourse. Thus, my ideas about transformative dialogue provide me with the opportunity to clarify what I call social construction and how I see social construction in relation to inclusiveness in therapeutic theory and practice as well as resonant with the dialogic spirit of family therapy.

Therapy as social construction[4]

Let me begin by talking about social construction as a *philosophical stance* (Anderson, 1997), rather than as a model or method for

[4] For a more thorough discussion of therapy as social construction (as opposed to social constructionist therapy) see McNamee, 2004.

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therapy. Over the past decade there has been confusion surrounding social construction and its relation to family therapy. Since the publication of *Therapy as Social Construction* (McNamee and Gergen, 1992), the temptation to brand certain styles of therapy as *constructionist* has implied that there are some models that *are* constructionist and some that are not. What I would like to clarify here is that the title of the 1992 volume was purposive: *Therapy as Social Construction* (emphasis added). Therapy is a dialogic process whereby participants – therapist and clients – actively create meaning (and thereby possibilities and constraints) *together*. Taken this way, *any* theory or model has the potential to inform the generation of useful meaning for clients and therapists alike. The potential of any given theory or model is contingent upon the participants and their abilities to resonate with a particular way of talking. Simply put, if cognitive-behavioural therapy is a resonant form of engagement for a given family, then it is most likely an effective form of 'treatment' in that particular relationship.

This returns us to our earlier distinction between science and scientism. Using a particular model of therapy because it has been empirically proven to be effective might have little to do with whether or not that model will be 'effective' with a particular client. Therapeutic approach has little to do with successful therapy. Effective therapy requires a collaborative therapeutic relationship that engages 'a person's expectations and hopes for change as reflected in their personal narrative and lived relationships' (Larner, 2004, p. 23).

Approaching therapy as dialogic, as a process of social construction, I believe, allows us to engage in this way. Social construction offers us a stance for engaging in the therapeutic relationship. When we talk about *therapy as social construction* we are not emphasizing a particular technique or method but rather a way of talking about therapeutic process. Therapy as social construction is a conversational process (McNamee, 2004).

Building on the theme of therapy as a dialogic process, we can explore how different theories and models of family therapy might be seen as *entries into a conversation* rather than viewed as 'the answer' to therapeutic success. Looking at the field of family therapy over the past several decades, we can list numerous models: structural (Minuchin, 1974), systemic (Palazzoli *et al*., 1978), collaborative language systems (Anderson, 1997), symbolic experiential (Whitaker and Keith, 1981), solution-focused (de Shazer, 1985), narrative (White and Epston, 1990), among others. Each of these *conversations* (models)

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prescribes what is to be viewed as central which, in turn, determines what we should look for, what questions we should ask, what ways we should talk about families and so forth. The therapeutic conversation is *open* yet *closed* – open to various constructions (known as 'discoveries' in a representational orientation), yet closed to others.

Let us look at an illustration. If I follow Minuchin's (1974) structural model, I am exploring boundaries, hierarchies, coalitions and so forth. My conversation is indeterminable yet *contained*. If, on the other hand, I am trained to use the solution-focused approach, I enquire into moments that are 'problem-free'. My attempt would be to provide space for conversations focused on moments when the problem was *not* present, thereby giving less credibility to the power of the problem itself.

The structural and solution-focused therapists *speak* a different language and, when confronted with one another, it is as if two incommensurate communities were attempting to figure out 'who has got it right'. Since both structural and solution-focused therapy offer generative resources for family transformation, our challenge is to *coordinate these resources* (and the multiple other resourceful models) to enhance our therapeutic work. Is such coordination possible? I believe it is if we allow ourselves to be promiscuous.

If we are a little more promiscuous – that is, if we mix things up a bit – might we then begin to see *each* model and theory of therapy as a potentially useful way to construct a future together with our clients? To me, this is what we are referring to when we talk about therapy as social construction. It is a process of constructing a viable reality *with* our clients. In addition, that viable reality cannot possibly come prepackaged, ready to use, for all clients in all situations because we can never know ahead of time what resources, what values, what stories, our clients bring to the therapeutic conversation. Constructing a way of being in the world, a way of talking, acting and interpreting involves the coordination of participants. This is the case both for our therapeutic conversations with our clients (where we create a local way of being together – a reality) and together with each other as colleagues developing theories and models of practice.

As any community coordinates its activities, it generates, over time, standards and expectations. In the present case, we could say, as theorists and practitioners work together, that they develop a model for practice (let us say structural therapy). As these participants coordinate their activities, they generate expectations about, for example, what questions should be asked in therapy, how they should

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be asked, why they should be asked and so forth. These emergent standards generate, in turn, a sense of value in how things should be done and what is good. Ultimately, over time, a tradition has been established – a reality constructed if you will. To talk one way is to participate in culturally embedded practices of interpretation. In the current illustration, models or theories are accomplishments born out of communal practices. However, without curiosity and reflection, such coordinated activity can invite routinized professionalism marked by its distance from clients and the particularities of their lives. Once a professional 'knows what to do', the engagement with clients is minimized. As jazz pianist and organizational theorist Frank Barrett says, 'Habit creates competency traps' (personal communication, 1997). Let us explore some of the negative by-products of this tendency towards consistency in method or model:

- one model is prioritized regardless of the ability of the therapist to coordinate with the client (i.e. the therapist *could* be seen as focused on his or her own goals, rights or needs where focus is on how well she exemplifies use of the model or theory);
- with professionalism as the goal, there is the generation of a sense of basic isolation or independence between and among forms of practice, theoretical models and schools of thought;
- this isolation generates constant questioning of one's professional standing – either in the sense of wondering if one 'makes the mark' or in the sense of oppressing others who don't make *our* mark;
- thus it becomes difficult if not impossible to talk across models, and with no possibility to connect, we retreat to our own 'private' practice;
- finally, we might easily find ourselves locked into unending conflict with our colleagues over our incommensurate moralities and ideological commitments where our clients are caught in the midst of our professional battles.

We must ask: Is this useful? In describing dialogue, Stewart and Zediker (2000) use the metaphor of tension. They describe dialogue as the tension between 'holding one's own' in a conversation and 'letting the other happen to oneself'. This tension, this form of coordination, *requires* participants to hold neither their own nor the other's view in its pure form. Each participant entertains the other's position *in relation to* their own. By 'letting the other happen to you' as you 'hold your own', the position from which you speak integrates, in

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some way, the other. This is the relational focus of dialogue (and of social construction). It is more than a simple *acceptance* of another's point of view. In fact, in dialogue, acceptance or agreement are not necessary. What is necessary is allowing space for the other.

In the case of family therapy theories and models, this translates into attentiveness to alternatives. We do not need to accept other models or to agree with them. Yet, if we become curious about them as useful models and theories for some and consider how that might be, we are 'letting the other happen to us'. And, most important, in letting these models and theories 'happen to us', our own (perhaps previously dogmatic) models and theories are responsive to, somehow connected with, these different perspectives. We generate the sort of promiscuity that invites inclusiveness among theories and practices of family therapy.

How do we engage with each other, with each other's models and with our clients if we insist on speaking only one language? If we follow only one model, we might limit the possibilities for personal, social and communal change. Our attempts to be competent professionals might not only alienate us from each other but from our clients as well. If we continue to argue for theoretical and methodological purity, we slowly narrow the professional spaces within which we can move.

Perhaps more important is the way in which our attempts at professionalism begin to craft forms of oppression, pathology and deficit in the culture at large. We begin, for example, to believe that the miracle question is the only way to move beyond personal difficulty. That focus on the problem *is always* the problem and we should instead consistently, and with rigour, attend to solutions. Our professional purity, while a beautiful elaboration of skill, competence and even art, becomes the limit of our world.

Focusing on the problem ignores what works. Focusing on what works ignores what may be learned from examining the way we talk about problems. To say something is good implies a standard within a tradition. In sum, our theoretical differences generate conflict. In addition, when we confront conflict we tend to avoid other models, to simplify them, and explain them in negative extremes. When we do these things, we engage unwittingly in practices of stigmatization where the implicit value system of each model is embraced with purity, thereby demonizing all other models and their implied systems of value.

Because of the valuational component, our attempts at professionalism are not neutral. Our professionalism does not merely describe

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another model or method. It emerges as a *moral judgement*. It communicates *deficit*:

- 'You are not concerned with issues of gender'/'You are too concerned with issues of gender';
- 'We should never engage in problem talk'/'We should always engage in problem talk';
- 'It is important to know the pattern'/'Knowing the pattern is impossible. We can only know how people talk about the pattern.'

There is little way to escape once stigmatized.

Professionalism also invites us into the discourse of blame. We critique each other's therapy. 'Your model leads you to be oppressive/you are maintaining the problem/you are ignoring the problem.' This, of course, invites others into a posture of counter-blame. Each moves into a mode of self-defence. In defending one's own practice, one quickly finds oneself in heated debate. Debate dominates the dialogic alternative where competing models can coexist.

Professionalism can also invite us to disrupt communities and their associated practices. Rather than see a form of practice as innovative within its own terms (i.e. within the conversations from which it emerged) or within a particular community, we try to obliterate it because it is 'outdated' or because it is 'gender, race, or economically blind'. Can't we ask, instead, what part of cognitive-behavioural therapy, of solution-focused therapy, or of cybernetics is useful rather than implying inferiority of other traditions?

Related professionalism can also support the deterioration of relationships. It often disrupts the processes of relational engagement that might otherwise take place within the community because the focus of those engaged is in debating the merits of their own orientation while pointing to the flaws of others' models. Rather than debate the merits of one model over another, can we engage in dialogues that knit us together by virtue of a focus on innovation or strength or success?

Finally, professionalism invites a form of disempowerment. By remaining true to one form, to one way of talking, to one set of assumptions, we blind ourselves to alternatives. In this way, professionalism offers no innovative resources when the old moves wear thin. We find ourselves 'doing therapy' the way we do because 'that's the way it is supposed to be done' rather than opening any space for

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reflection upon the situated conversation we are having with a *particular* client.

Thus we can see that our challenge is not to create a world where we all agree on what model to use (because it is *right*), but rather to ask how promiscuity can assist us in moving beyond theoretical and practical unity. After all, don't we want the most abundant resources at our disposal to be the professionals we aspire to become? To avail ourselves of an abundance of resources demands that we engage the tensionality of dialogue of which Stewart and Zediker (2000) speak. We come to our professional conversations – whether they be with clients or with colleagues – with well-formed and privileged models. We 'hold our own' models while we 'let the other happen to us'. That is, we listen to the ways in which the other's model, techniques and assumptions help us expand or alter our own model, techniques and assumptions. We hold the tension between these two poles rather than 'reloading' (Isaacs, 1999) while the other speaks. We enter into conversation *anticipating* that our views will be altered, amended and enhanced rather than entering a conversation striving to leave it untouched by the other. In the former, we engage in processes that facilitate ways of going on together (Wittgenstein, 1953). Social construction offers the promiscuous stance we might find useful for participation in this tension of dialogue.

Social construction and the stance of promiscuity

As we have seen, language is the focus of our concern. It is in language that we create the worlds in which we live. Thus it should come as no surprise that in talking about therapy theory and models, we are focused on the discourse of all models and how particular discursive moves constrain or potentiate different forms of action and, consequently, prohibit or enable different realities. This is a liberating stance because it generates curiosity. When we become curious, as opposed to judgemental, about how people engage with each other, we open ourselves up to the consideration of alternatives. This particular feature is often associated with the constructionist focus on *uncertainty*. Attention to language (as a form of embodied activity) positions us in a reflexive relationship to our own actions as well as to the actions of others. We are poised and prepared to ask, 'What other ways might I invite this client into creating a story of transformation?' 'How is she inviting me into legitimating or transforming or challenging…her story?' 'What other voices might I use now?' 'What other

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voices might he use?' Each model of family therapy becomes another *voice*.

I find it useful to be attentive to how we might focus on our engagement with other models. Constructionism is not a technique and it is neither a more pure nor a *more correct* philosophical stance. Rather, constructionism is an orientation that privileges what is happening in the conversation – in the present case, the conversation among and between different models of family therapy. Can we call constructionism promiscuous? The focus is on dialogue – *how* we *bridge incommensurate models (belief systems, realities)*, not on merging different models into one meta-narrative. This is a significant difference because it positions the therapist in an open manner to *any* method of therapy. Narratives – solution-focused, cognitive-behavioural, or psychoanalytic therapy – all become *potentially* viable and generative ways of engaging relationally with each other as well as with our clients. The challenge is to see a model, technique or even a theory as a *discursive option*. This is what constructionism invites us to do and, to that extent, constructionism may be called promiscuous.

However, does this mean that all models are equally viable? Does it mean that anything is OK? If so, why bother training professionals? On what grounds should clients seek professional help? The dialogic stance does not preclude evaluation. Promiscuity, as I am proposing here, does not place all therapeutic approaches on an equal footing. Nor is the expertise of the therapist tossed aside in favour of the client's control. The promiscuous stance I am proposing simply invites us into a dialogue rather than a debate. It acknowledges that there are good and bad therapeutic relationships and therapeutic treatments. What is up for grabs is not the notion of a standard, itself. Rather, what is open to collaborative construction is the form the standard takes and who has the opportunity to participate in the creation of that standard. To this end, promiscuity encourages multiple resources and discourses into the conversation. These diverse world views are present in the dialogue not for purposes of emerging as the best or the true, but rather they are responsively present to different possibilities that can potentially emerge from each.

Theories as discursive options

Any particular discourse (or, in this case, any particular theory or model) becomes a potential resource for transformation rather than a tool that will *bring about* (read: cause) transformation. Promiscuity, as a

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stance, tunes us into the interactive moment[5] where therapeutic change might be possible. The challenge, of course, is that there are no specific techniques, nor are there any desires, to determine which ways of talking are therapeutic and which are not. The question of what is therapeutic remains open and indeterminate, just like conversation. When therapy is understood as a *conversational process*, we can never be certain where it will go. I can never fully predict another's next move and consequently, the potential for moving in new directions, generating new conclusions and possibilities (and constraints) is ever-present. What we can do, however, is to remain attentive to what conversational resources we select and which ones might serve as useful alternatives. This stance of promiscuity has implications for therapeutic practice.

Generating therapeutic practice from a stance of promiscuity

Selecting a theory or technique as a *practical option* (as opposed to a truthful option) for action enhances our ability to be relationally engaged with clients. We become sensitive to their stories as well as to our own stories in ways that allow us to be responsive and relationally responsible (McNamee and Gergen, 1998). There are many ways in which we might pragmatically achieve such a responsivity. I would like to identify two conversational themes that could encourage the sort of promiscuity I am proposing. Let us take a brief look at these themes and consider how each might be useful in approaching therapeutic process as a conversational activity, and thus constructing the potential for a range of therapeutic practices.

Using familiar resources in unfamiliar places

Tom Andersen (1991) talks about introducing not too much change and not too little change but just enough change. He echoes Bateson's well-known phrase, 'the difference that makes a difference' (1972, p. 272). Here, when I talk of using familiar resources in unfamiliar domains, I am suggesting a variation on this common theme. We all carry with us many voices, many differing opinions, views and

[5] The interactive moment refers to the moment-by-moment engagement of individuals in their situated activities. This focus on what people are doing *together in the moment* is not, however, devoid of the historical and cultural resources available to them. In other words, social construction, with its focus on the interactive moment, does not move all social interchange to either a level of abstraction such that there is little left to inform participants how to go on; nor does it move to such a singular level of activity that any interchange is capable of being viewed as a-historical and/or a-cultural.

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attitudes – even on the same subject. These voices represent the accumulation of our relationships (actual, imagined and virtual). In effect, we carry the residues of many others with us; 'we contain multitudes'. Yet most of our actions, along with the positions we adopt in our practice of therapy, are one-dimensional. They represent only a small segment of all that we might do and say. The challenge is to draw on these other voices, these conversational resources that are familiar in one set of relationships and situations but not in another. In so doing, we achieve *just enough difference* as Tom Andersen proposes.

Using unfamiliar resources in contexts where we generally use our familiar (or pet) model invites us into new forms of relational engagement with others. If we think of all our activities as invitations into different relational constructions, we can focus on how using particular resources invites certain responses or constructions in specific relationships and how it invites different responses and different constructions in others. Let me elaborate by focusing attention, for the moment, on the issue of professional identity.

We inherit from our tradition the expectation (assumption) that there is a proper way to be a professional therapist. We often see it in trainees when they begin seeing clients. They are more likely to talk as they believe a therapist *should* talk, thereby ignoring those conversational resources that are familiar specifically to them. The familiar becomes alienated and what has previously been alien (e.g. the identity of therapist) is miraculously supposed to be familiar! This reminds me of my own clinical training. As a researcher of therapeutic process I spent years interviewing families, couples and individuals about their therapy. After many years as a researcher I decided to take the plunge and train to become a therapist. When I finally initiated my training I found myself almost speechless with clients. Not only did I have a hard time thinking of questions to ask (regardless of how much pre-session time had been spent generating hypotheses and questions), but I was constantly monitoring myself for *how* I asked questions. I wondered endlessly about whether or not everything I did or said was 'right', given my new role as therapist. Were my questions circular enough?

One day, while sitting with a client, my supervisors called me out of the room. They asked one very simple question: 'Are you comfortable and confident when you interview people for your research?' My response was in the affirmative. They said, 'Then go back in there and act like a researcher.' This directive was so liberating for me that I forgot my fear of *acting like a therapist* and simply engaged in

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conversation with the client. What I realized in this moment was how our attempts to be good professionals actually can prohibit our ability to be relationally responsive (as professionals) in our conversations with clients. I also realized the benefit of using a familiar repertoire in a context where I would not expect it to serve as an appropriate resource. If we can encourage ourselves (and others) to draw broadly on the conversational resources that are already familiar, perhaps we can act in ways that are *just different enough* to invite others into something other than the same old unwanted pattern.

This idea, I believe, is distinct from what we expect of ourselves as therapists. We expect (and our clients expect us) to converse within a limited and pre-legitimized range of topics and terms. That range is dictated by the theory within which we practise. Thus for the behavioural therapist all conversation is drawn from the realm of learned patterns of behaviour and associated concepts. The novelty in using theories or models as forms of discourse is that doing so allows us to engage in a responsive way with our clients. We are free to abandon the need to persuade clients that our knowledge of their problems is not only authoritative but correct. Instead, we can engage *with* our clients in collaboratively constructing (even if our part of the collaboration is from the *achieved* stance of authority) alternative ways to talk and act about and within their life circumstances.

Focus on the future

The second theme I would like to propose, in an attempt to enhance promiscuity, is that of embracing the fantasy, the unknown and the uncertainty of the future. I do not mean to suggest here, however, abandoning our interest in the past. Instead, I would like to propose that we embrace a both/and stance, but in the current moment, to fix our attention more pointedly on the future. If we examine the field of therapy, we can note that a good deal of therapy talk hovers on the past. Therapists and clients alike explore the history and evolution of the problems that clients bring to therapy. When did the problem begin? How long has it been a difficulty? How have you come to understand the problem? What do you think causes the problem? What do others say about it (and you)? What have you done to try to solve this problem? The questions that therapists ask direct the therapeutic conversation towards the past, as do the expectations that many clients bring to therapy. Most cultural presentations of therapy (consider any Woody Allen film, for example) portray client

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and therapist locked in a conversation about the past (childhood, adolescence, former failed marriages, and so on.).

With such an emphasis on these past-oriented questions, there is little room for imagining the future. The potential to sediment the past, to reify the story, and thereby make it static and immutable is tremendous. Probably more important is the logic inherent in the therapeutic focus on the past. By focusing on what has already transpired, we unwittingly give credibility to causal models that are the hallmark of modernist science. We privilege the logic which claims that what went before causes what follows.

As a constructionist, I do not necessarily want to argue for a disconnection between past, present and future. I simply want to raise the issue of narration. The past is always a story, and we all know that there are many ways to tell a story. Not only do we harbour many voices, each with a different set of possible narrations, but others involved in the same 'history' will very likely narrate it differently. Thus the causality of past to present (and implied future) will take different turns, highlight different features and pathologize varied aspects, depending on which story is privileged.

One reason that future-oriented discourse enhances promiscuity is because we all understand that we do not yet *know* the future. We have not yet embodied it. And thus, to the extent that we engage *with others* in conversation about the future, we underscore the relational construction of our worlds. We fabricate together what we might live into. We liberate ourselves to 'mix things up'.

This is not to suggest that talk of the past is emblematic of 'bad' therapy. I am not arguing for solution-focused therapy over psychoanalytic therapy, for example. Instead of privileging a particular way to talk and/or particular themes or topics for therapy, constructionism emphasizes the collaborative, situated creation of possibilities and *one way* to achieve this is with future-oriented discourse. The question I urge us to engage is how, as therapists, we might *imagine* 'mixing it up'?

Promiscuous family therapy

Let me review what I see as the specific issues promiscuity raises for therapeutic practice. First, mixing theories presents a challenge to traditional notions of expert knowledge and professional neutrality. It is not the case that constructionists do not recognize expertise or authority. What constructionists call into question is the *unquestioned presumption* that the therapist *should* be the authority (and that it is only

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through the therapist's expertise in one model that therapeutic success can be accomplished). I would like to suggest that the task at hand is one of coordination among models. Recall earlier my emphasis on bridging as opposed to an emphasis on making incommensurate discourses commensurate. Bridging requires coordination, and coordination could likely include a wide array of possibilities. It could include, for example, problem talk, diagnosis and an authoritative stance taken by the therapist. It is also likely that it may require the therapist to adopt the stance of a conversational partner who does not know with certainty how to understand or make sense of the client's problem. Furthermore, it may involve conversation about possibilities, potentials and ideals. The point is, from a constructionist stance, we cannot know ahead of time what will be the most generative therapeutic practice for any given client.

Second, constructionism raises the question of focus in a therapeutic conversation. Traditional therapy focuses on the past to understand the present. Therapy informed by a constructionist sensibility places focus on the *interactive moment* – the past, present and future *as they are narrated in the present*. To that end, rather than attempt to provide clients with new resources for action, therapy attempts to help clients use the conversational resources they *already have* in new and unusual conversational arenas. In addition, the therapeutic conversation might focus on the future, as well as on the discourse of the ideal.

Finally, there is a difference between ignoring the past (as it is narrated) and valuing participants' understandings of the past as coherent, rational and legitimate. With constructionists arguing for attention to the interactive moment, a great deal of confusion has emerged about *how* a therapist can honour the client's desire or lack of desire to focus on the past. *Talk about the past always takes place in the present*. The 'rationale' for talking about the past is not, for the constructionist, to delve into the causes of the client's problem. The past need only be discussed inasmuch as the client finds relevance in telling his or her history. And, when this does, in fact, have relevance for a client, the therapist who sees therapy as a process of social construction can explore how to move on from a value of the past (respect for the past) to the creation of a generative future.

Implications for the therapist and for therapy as a profession

In the face of competing models and methods, the tendency to slip into that sinking sense of uncertainty is heightened. The *structured*

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expectations of therapy that have emerged as a result of scientism (symbolized here by professionalism and in the field at large by the current demands of evidence-based practice) has increased the possibility of adopting a self-deprecating uncertainty (e.g. 'Systemic therapy is not rigorous enough'). Alternatively, the uncertainty that is associated with constructionism is one which invites multiplicity and thereby invites therapists and clients alike to question their assumptions and explore alternative resources for personal, relational and social transformation. Uncertainty invites promiscuity. We could call this *generative uncertainty*. Generative uncertainty encourages us to be responsive to the interactive moment. The therapist is now a conversational partner who is free to move within the relationship in ways that enhance both therapist's and client's abilities to draw on a wide range of conversational resources. The therapist is not burdened with being 'right' but with being *present* and *responsive*. The therapist and client become accountable to each other. Yet accountability, presence and responsivity to each other is not enough. Our conversations in the therapeutic context might be more usefully centred on broader community transformation. How might we, as therapists, invite clients into the sorts of relationships that effectively transform our ways of living communally together. To this end, constructionism would suggest that our understanding of the term *therapeutic practice* expands well beyond the therapist–client relationship.

My comments here raise several important issues; issues that must be addressed within the profession. These include questions of evaluation, ethics, expertise and training; but, for the moment, let me address only two: evaluation and training. What are, for example, the implications of a promiscuous stance towards theory and practice for our assessment of therapeutic effect? With the dominance of evidence-based practice, we are challenged to explore the means by which we can say that our work as therapists is successful. Rather than look to models that guide our practice, might we be better situated if we look closely at the therapeutic conversation, the therapeutic relationship, and construct (with our clients and colleagues) evaluation standards that are suited to a particular situation? Is it appropriate, we might ask, to employ abstract standards to a specific interactive moment (see Larner (2004) for an excellent discussion of the politics of evaluation)? Obviously, such a move would require a complete rethinking of how we engage in evaluation and, more important, what evaluation means. Whose standards are being used? To whose purposes? Who is left out? As Larner (2004) puts

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the question: 'who controls the definition of evidence and which kind is acceptable to whom.' These are dramatically important questions. The challenge for family therapy as a discipline is to move beyond critique of evidence-based practice and instead join in the activity of evaluation. Create the standards, apply the standards, test the various family therapy models against the standards; but make sure the standards are as fluid and flexible as the situated activities to which they are applied (e.g. therapeutic treatment). Participation in evaluation rather than detached critique is yet another elaboration of promiscuity.

Training, in addition, requires serious reflection. Can we be promiscuous only *after* we have been fully trained within one theoretical model? Does promiscuity *require* initial dedication to the study and practise of one model? What is the distinction between being devoted to a model or theory and 'holding one's own', as Stewart and Zediker (2000) suggest? Can we only become promiscuous once we have worked with a number of different clients in a number of different contexts? How do we create training programmes that build a freedom to 'mix things up' into the very fibre of the trainees' experiences? These are very difficult questions with no one answer.

If we draw on the idea of promiscuity itself, we might recognize that there is no singular way to prepare to become a therapist, since there is no singular method for evaluation. Perhaps promiscuity as a metaphor reminds us not only to mix things up but to recognize risk in the very simple practices with which we engage. The risk to question what standards and what practices are being used to evaluate the success of therapy, as well as the risk to question what will count as a generative training programme, emerge from a stance of promiscuity. I invite us all to be promiscuous, to rekindle the revolutionary spirit of family therapy, in an attempt to build inclusiveness into theory and practice.

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